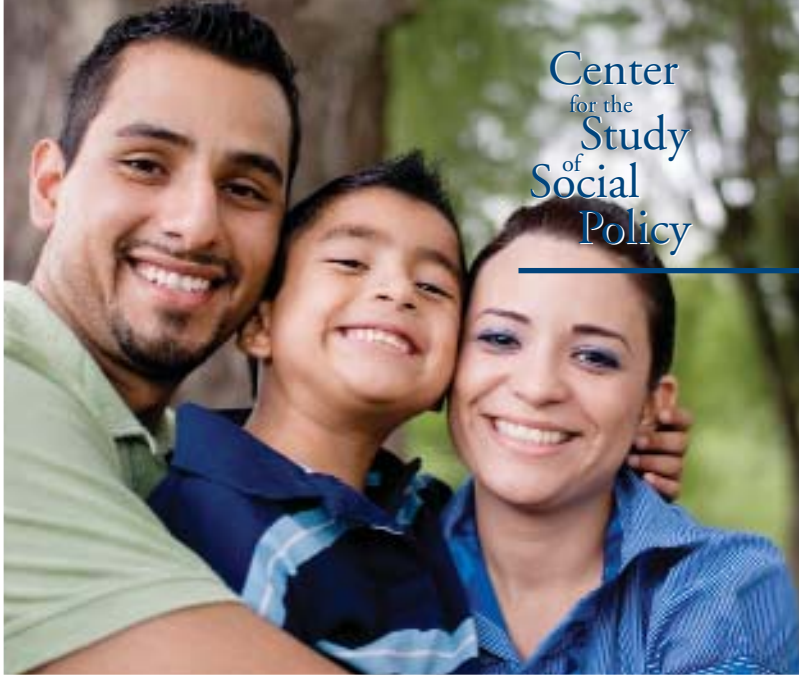

Center for the Study of Social Policy

PolicyMatters

Setting and Measuring Benchmarks for State Policies

Promoting Child Safety, Permanence, and Well-Being Through Safe and Strong Families, Supportive Communities, and Effective Systems

A Discussion Paper for the Policy Matters Project

POLICY MATTERS:
Setting and Measuring Benchmarks for State Policies

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A DISCUSSION PAPER FOR THE *POLICY MATTERS* PROJECT

Center for the Study of Social Policy

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Preface

About the Center for the Study of Social Policy

The Center for the Study of Social Policy is a non-partisan, non-profit research and technical assistance organization located in Washington D.C. and with an office in New York City. Our mission is to develop public policies and practices that strengthen families and communities to produce equal opportunities and a better future for all children.

About the Policy Matters Project

The *Policy Matters* project provides coherent, comprehensive information regarding the strength and adequacy of state policies affecting children, families, and communities. The project seeks to establish consensus among policy experts and state leaders regarding the mix of policies believed to offer the best opportunity for improving key child and family results. A series of policy briefs, policy papers, guides for self-assessment, and 50-state comparative reports are produced through this work. The project focuses on seven core results: school readiness, educational success, family economic success, healthy families, youth development, family relationships, and child safety and well-being with permanent families. We believe these seven core results comprise one composite family-strengthening policy agenda, emphasizing the importance of both individual results and the interaction of multiple results.

About This Paper

The paper that follows presents a framework for policy options aimed at achieving a core result: safety and well-being for children with permanent families.

Although there are many systems, policies, and programs that affect this outcome, this paper focuses primarily on state child welfare agencies and their partners, which include the courts and systems responsible for health, mental health, education and other related services. In Section I, the paper provides background on the challenges faced by children and families involved with the child welfare systems, and the challenges these systems face in trying to serve them. Section II of this report provides a conceptual framework and logic model that illustrate the connection between the desired outcomes for children and the policy recommendations in this report. Section III defines these policy recommendations in detail, including the available research and practice evidence that informs these recommendations.

Taken together, we believe that the policies identified here present a powerful and compelling policy agenda for improving child safety and well-being as part of permanent families. Over time, we will continue to improve the recommendations as additional research and practice evidence is available. Future policy options may be modified to allow consistent tracking of state progress and to overcome data limitations. Thus, this paper presents a preliminary set of policy options.

A goal of the *Policy Matters* work is to assess states' progress toward recommended policy options. The framework helps states think strategically about policy decisions that improve the safety, permanence, and well-being of families, and is designed to provide policy support and feedback to those interested in promoting improved outcomes for children and families.

Introduction

BACKGROUND

All children deserve the opportunity to develop and grow as part of a safe and nurturing family, and research shows that caring family relationships are critical to achieving positive outcomes for children. At times, however, parents face overwhelming challenges in their lives and need help to provide adequate care for their children. If parents receive timely and quality support during these times, children are more likely to experience safety and well-being, and families are more likely to remain intact. If no such help is available, however, temporary setbacks can become major crises. Child welfare systems play a major role in providing critical assistance to families in need. While these systems face significant challenges, major opportunities exist for adopting state policies that can help improve the key factors that impact child-safety and well-being: ***safe and strong families, supportive communities,*** and ***effective systems***.

Key Factors Affecting Children

Three primary factors are critical to achieving positive results for children involved with the child welfare system: safe and strong families, supportive communities, and effective systems. These factors serve as the organizing framework for the policy recommendations in this report.

Safe and Strong Families

Research shows that children are most likely to thrive in their own families. At the same time, children involved with child welfare systems usually experience a variety of risks, and their families often experience multiple risk factors, such as substance abuse, mental illness, inadequate housing, and domestic violence. To reduce the harm these risks and vulnerabilities pose to children, children benefit when families can develop enhanced factors that increase the health and well-being of children, and serve as buffers against stress. Research confirms that a range of supports can help families care for their children more effectively.

When out-of-home placement is necessary, children fare better if family connections are maintained. This can be accomplished through measures such as placing children in the care of willing and able relatives (including kin with whom children have close emotional relationships), keeping siblings together, and frequent parental visitation. To promote permanence and well-being, the priority is on safely reunifying children with their parents as quickly as possible. When reunification is not possible, safety and permanence with a strong kin or adoptive family becomes critical. To promote safe and strong families, this report includes numerous policy recommendations focused on building the capacities of parents and other caregivers and enhancing developmental opportunities for children involved with the child welfare system.

Supportive Communities

In this report, community is defined as not only a geographic space, but also as a network of neighbors, service providers, and advocates who help represent and serve the needs of families involved with the child welfare system. As such, supportive communities are essential to the safety and well-being of children as part of permanent families. A family's community plays a significant role in determining its access to resources. This is especially true for families in poverty, who are more reliant on immediately accessible resources in their community. To this end, this report identifies opportunities for child welfare agencies to develop partnerships within communities to help define and deliver needed services in a manner best suited for local children and their families.

Effective Systems

All children and families are affected by public systems, including education, health, and economic support systems, and the effectiveness of these systems is essential to the safety and well-being of families. Families involved with child welfare systems are especially vulnerable to other powerful public systems — including police, courts, and child welfare agencies — and therefore are especially vulnerable to how responsive, effective, and well-managed these systems are, and how well they work

together. Similarly, child welfare systems are subject to powerful forces, including a large and complex body of state and federal requirements, major funding challenges, and extremely high public expectations for achieving positive results with a very vulnerable population.

Elements key to system performance discussed in this report include the quality of decision-making processes and the role of families in these decisions, the effectiveness of courts, the competence and stability of the child welfare workforce, and the ability to hold the system accountable for treatment of and consequences to children and families. In discussing systems outside of child welfare agencies, this report only examines system components directly relevant to key child welfare functions.

Societal and Systemic Challenges Faced by Families

The environment in which child welfare systems operate is further complicated by multiple societal and systemic challenges faced by families, and these challenges must be taken into account in order for state policy changes to positively impact children.

Poverty

Children who grow up in poverty are more likely to come to the attention of child welfare than those who do not — in part this is due to the additional stresses that dealing with poverty places on parents and children. The hardships associated with economic deprivation present child welfare systems with the significant challenge of separating the concept of neglect from a parent's inability to provide for their children's material needs. As such, the policy recommendations in this report highlight the critical role of economic assistance that, if targeted appropriately, can provide parents the crucial resources needed to maintain their families intact and nurture their children.

Racial Bias

A mounting body of evidence is revealing significant racial bias inequity in the treatment of families of color by child welfare systems. For example, research shows that African American families are no more likely to abuse or neglect their children than white families, yet African American children in circumstances comparable to white children are more likely to be removed from their parents by child welfare systems and courts. Based on these findings, the policy recommendations in this report aim to assist policymakers in identifying bias in how African American, Native American, Latino and other children and families of color are treated and to hold systems accountable for treating all children and families fairly and effectively.

Interaction of Multiple Systems

Families experiencing crises in caring for their children often face multiple challenges, and are likely to need many a variety of assistance from more than one program, agency or service system. Often, children and families slip through the cracks — systems simply do not respond to their needs, exacerbating risks and failing to strengthen the factors that help children thrive. When multiple government agencies do become involved, these vulnerable families typically experience a tangled (and sometimes counteracting) web of requirements, directives, contacts, and services. As policy makers seek to improve the lives of children and their families, the responses of these complex systems and underlying policies must be coordinated and focused on achieving results.

The Approach Taken in this Report

In light of the factors affecting children and the challenges of the system intended to help them, this report aims to present both a broad framework for developing policy as well as specific policy recommendations. It focuses on state level as a critical point of influence for policymakers and advocates who are concerned with child well-being, and uses a structured set of criteria for defining policy recommendations.

Policy is defined here as statewide directives that drive critical decision-making processes, resource allocations, program implementation, and practice models related to the child welfare system. Policy is at times set by the executive branch through administrative directives, regulations and budget allocations; by the legislature through laws, appropriations, and oversight; and by the judiciary through court rules and allocation of judicial resources.

Focus on State Policy

This report focuses on opportunities for improving state policies. Although the federal government wields tremendous influence by developing directives and providing funding, and local governments in some states play a critical role in implementing child welfare policies and programs, child welfare policy is largely shaped by state policy. At the state level, policy makers define the services available for children and families, ensure that diverse systems work together in a coordinated fashion, and hold public agents accountable for achieving results within these systems. In addition, state policy makers provide incentives and resources to advance practice innovations, authorize expansion of exemplary practices, and provide safeguards to ensure the effectiveness of services for children and families is maintained.

Criteria for Selecting Recommended Policies

The policies described in this report represent a beginning set of recommendations for improving outcomes for children and families who come to the attention of the child welfare system. The recommendations are not exhaustive but attempt to define a select set of policies that research indicates will contribute to improved child safety and well-being as part of permanent families. The following criteria guided the selection of policies with the strongest potential for improving well-being for children and their families. The policies:

1. Demonstrate effectiveness in research, evaluation, or other studies;
2. Are supported by collective wisdom of practitioners from the field;
3. Address children and families with the poorest outcomes;
4. Possess sufficient scope and scale to address the outcome;
5. Are politically and administratively feasible; and
6. Are compatible with the values and assumptions of a family-strengthening perspective.

When selecting policies for this report, special consideration was given to the quality of evidence supporting their effectiveness. Significant challenges exist. First, research and evaluation typically focus on the effectiveness of programs or practice models, not the policy that governs those models. Therefore, this report generally presents evidence supporting program or practice, then aims to identify the state policies that support the adoption, expansion, or enhancement of the program or practice.

This report also recognizes that evidence exists in different forms. The evidence cited falls into three main categories.

- ***Rigorous statistical research*** consists of the most scientifically defensible evidence, which is derived from evaluations that use control groups, randomly assigned participation, and tests of statistical significance. Research of this sort is rarely available in the field of child welfare, in part because of the complex variables that affect every case and because true random assignment is often ethically prohibited. Where scientifically rigorous research is available, it is important to exercise caution when interpreting and generalizing findings to entire populations involved with child welfare systems.

- The second category of evidence cited in this report includes ***non-scientific, evaluative research***. This category includes statistical research and studies that demonstrate success in operational programs or services, though they do not meet scientifically rigorous standards of evidence. Studies of this sort often present comparative data, information about program elements, and/or cost considerations that are relevant to existing policy and practice environments. This category of research also may also include extrapolations based on rigorous evidence gathered in related fields such as mental health or child development.

- The third category of research consists of ***practice-based evidence*** that reflects the best thinking of on-the-ground experts based on in-depth experience, field observation, and lessons learned.

The policy recommendations in this report are informed by evidence of all types, and the supporting evidence for each recommendation is explicitly and transparently identified.

For each recommendation, multiple policy options are presented to illustrate varying approaches that states may take in pursuing a policy. In some cases, individual policy options presented are discrete alternatives, and guidance is provided regarding which alternative is considered most effective. In other cases, the policy options listed are additive, meaning that more than one can be pursued simultaneously, and in these cases pursuing the greatest number of options available is considered the most effective course.

Challenges of Implementation

Effective implementation of a state policy can be as important as the policy itself. Some of the keys to implementation that must be addressed for state policies to have the intended impact include:

- Financing,
- Agency and professional workforce capacity and leadership,
- Quality service delivery (including program flexibility and local decision making),
- Public information and outreach,
- Accountability, monitoring, and data systems, and
- Interagency collaboration.

While this report does not include a thorough discussion of policy implementation, it does include selected recommendations related to each of these implementation challenges in certain, high priority areas.

Federal Policy Context

State child welfare polices exist within the framework set by several federal laws that guide state requirements and funding. Throughout this report, we reference provisions contained in federal legislation recently enacted through H.R. 6893, the Fostering Connections to Success and Increasing Adoptions Act of 2008 (referred to as "Fostering Connections"). This legislation provides new options for states to promote permanent homes for children in foster care and addresses some of the challenges that states have experienced while trying to achieve the federally

mandated outcomes of safety, permanency and well-being. Among other things, the legislation includes federally subsidized guardianship for relatives, elimination of the Title IV-E eligibility requirements for adoption assistance, and a state option to continue providing foster care assistance to youth through age 21. The legislation builds on over a decade of state and local experiments to achieve better outcomes for children in foster care, and demonstrates that state innovation can positively influence federal policy directions.

Despite the welcome advancements contained in the legislation, there are still federal policy concerns that hinder state efforts to promote safety, permanence, and well-being for children in the child welfare system. Some of these concerns are discussed in the policy recommendations section of this report. The two most prominent concerns are described below.

- ***Federal funding promotes foster care and adoption over keeping children safely with their own families.*** The majority of federal funding for child welfare is targeted toward room and board expenses for children in foster care and congregate care[1] and, more recently, for exiting foster care through adoption and guardianship.[2] Much smaller funding sources are available for services that prevent unnecessary removal of children from their families and for services associated with helping children return and stay home through family reunification. For example, such services include emergency funding to keep families together safely, post-adoption services, and services to treat substance abuse, domestic violence, and mental health issues. In 2006 the National Governors Association issued a policy statement calling attention to this concern and recommending that Congress expand the flexibility of Title IV-E funds while preserving this program as an open entitlement.[3]

- ***Title IV-E foster care eligibility provisions disqualify children in need.*** Eligibility for services under Title IV-E foster care is determined by a requirement referred to as the "look back" provision, which restricts eligibility to children with parents who meet the 1996 eligibility rules of the Aid to Families with Dependent Children program. This provision disqualifies many children in need by tying their eligibility to their parents' income, which may have no bearing on children's access to services once in care. Further, it uses income eligibility standards that have not been adjusted for inflation in over 10 years and therefore do not match current definitions of need. In addition, Title IV-E eligibility for members of American Indian tribes and residents of U.S. territories is subject to restrictive funding caps. The National Governors Association raised concerns regarding these provisions in their 2006 policy statement and called on Congress to expand eligibility to treat all children in the child welfare system equally and, at a minimum, to adjust eligibility levels for inflation.[4] In 2008,

Congress eliminated the "look back" standard for children who are adopted from foster care, but the linkage for children in foster care still remains.[5]

Although many federal obstacles still remain, the Fostering Connections legislation can help states make significant progress toward achieving better results for children and families in the child welfare system. As the federal legislation demonstrates, child welfare systems can make substantial progress toward better outcomes through effective state-level policy reform, and in turn, federal policy can take these reforms to a national scale. This possibility has already been demonstrated through the work in many of the states and counties that influenced the most recent changes at the federal level. For example, progress toward reducing the number of foster care placements in several jurisdictions strongly influenced the most recent round of federal changes.

These state and county experiences — and the recently enacted federal legislation — illustrate that carefully crafted state policy reform can yield results within states, and also help to positively influence the federal policy context. As the leaders of reform, states interested in continuing to improve child welfare outcomes can build on and sustain these policy innovations for continued improvement in state and national trends. This report attempts to capture the lessons from existing state and community experiences, as well as from research conducted across the country, to make further progress on the outcomes of safety, permanency and well-being. Recently enacted federal policy options that can further this progress are also highlighted. Finally, a comprehensive set of policy recommendations are summarized in Section III.

Introduction

A FRAMEWORK FOR STATE POLICY

B Key Definitions

Definition of Policy

This report defines policy as state-wide directives that drive critical decision-making processes, resource allocations, service delivery, and practice models related to the child welfare system. Policy is at times set by the executive branch through administrative directives, regulations and budget allocations; by the legislature through laws, appropriations, and oversight; and by the judiciary through administrative rules, allocation of judicial resources, and orders.

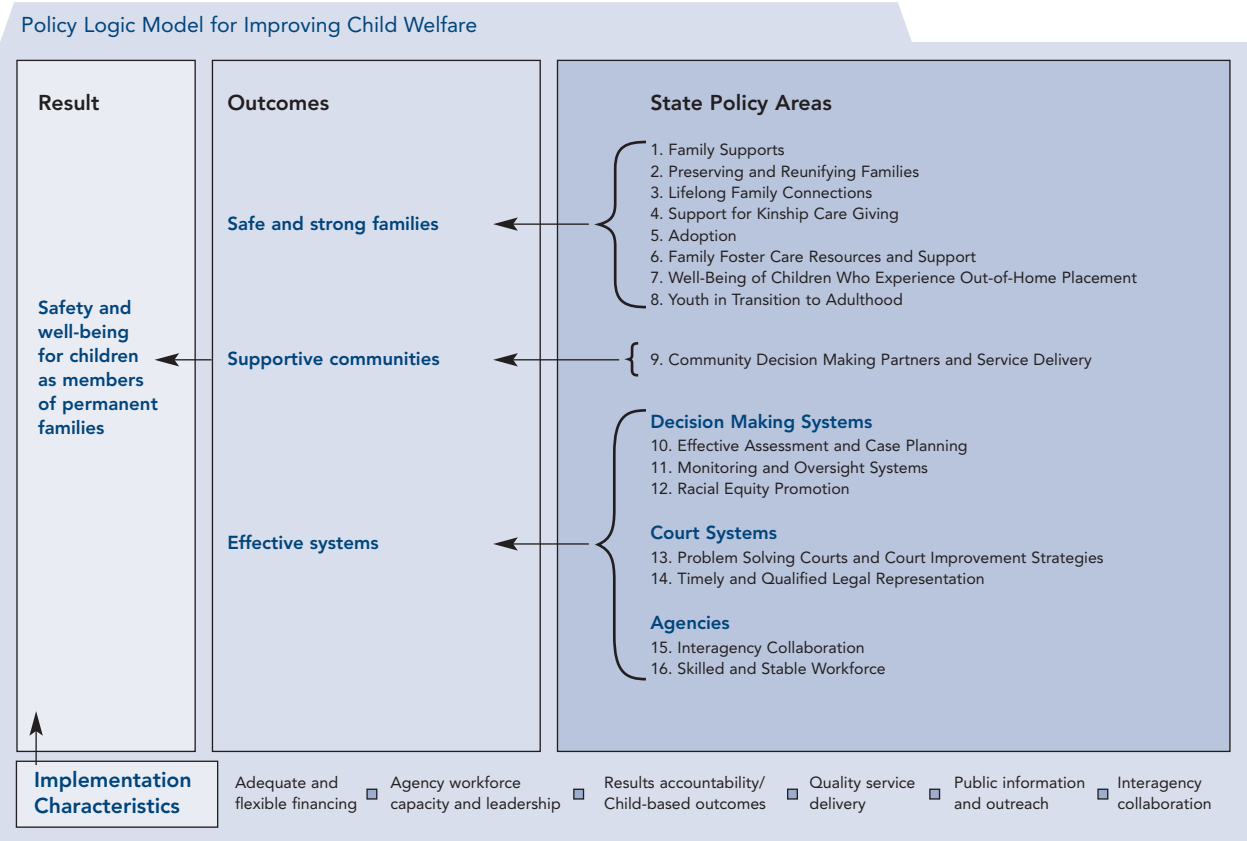
Definition of Benchmarks

In this report, a benchmark is defined as a point of reference from which measurements may be made, and/or something that serves as a standard against which others may be measured. Benchmarks convey not only the general idea of measurement but also set an explicit standard for performance. Where indicators measure a change in a result or condition (e.g., increases in age-appropriate child immunization rates), benchmarks measure such changes against an established standard. Consequently, benchmarks make possible certain judgments about the success or failure of a measured change that indicators alone do not.

For example, some children placed in foster care with a relative may be better served if their foster parent becomes a permanent legal guardian. All states provide subsidies to foster parents, but states may set subsidies to permanent guardians at a rate lower than that applied to foster parents. This inconsistency can create a challenge when a foster parent wishes to become a permanent legal guardian, as they may face a reduction in (or, in some cases, a complete loss of) needed financial assistance. Therefore, a policy discussion must not only examine whether guardianship subsidies are available, but also whether they are offered at a rate equal to or greater than foster care payments, which represent a standard or benchmark against which guardianship subsidies can be measured.

Policy Logic Model

The following policy logic model illustrates the conceptual framework for the policies that are recommended in this report related to safety and well-being for children as members of permanent families. This desired result is dependent on three conditions that evidence shows can be influenced by state policy: safe and strong families, supportive communities, and effective systems.



The most important message conveyed by this logic model is that in order to improve safety and well-being for children as part of permanent families, states must pursue a comprehensive set of strategies that focus on results. This report provides an inventory of policies that evidence indicates contribute to better results for children. However, it does not assess or rank the relative capacity of individual policies to impact results. Neither does it suggest priority strategies or criteria for selecting priorities within a state's existing policy context.

A New Online Resource Available: PolicyForResults.org

To assist state policymakers in selecting policy priorities informed by data and evidence and appropriate to state economic and political realities, the Center for the Study of Social Policy offers a set of online tools available at www.PolicyForResults.org. This interactive website provides a commonsense approach for:

- **Identifying strategies for tough economic times** including guidance on effective financing, budgeting and policy approaches to protect vulnerable families;
- **Adopting results-oriented policies** with evidence of effectiveness;
- **Helping governors, state legislators and other state policymakers** decide what works best for their individual states to achieve results; and
- **Using data to monitor child and family well-being** and inform policy decisions.

The website will provide policymakers useful information about:

- Policy options,
- Success stories from other states, and
- Research and hands-on tools for making effective policy decisions.

Policy guidance will focus on a variety of areas affecting child and family well-being, including child welfare, educational achievement, family economic success, juvenile detention, and others.

I. SAFE AND STRONG FAMILIES

Safe and Strong Families

1 Policy Area 1. Family Supports

All families — including birth families, kin, adoptive families, and foster families — experience challenges raising their children, and most need support at times. Often, families are able to find the support they need within their own informal networks of relatives, friends, neighbors, faith communities, and community-based organizations. However, if these informal supports are not available or adequate to counter the risks that children and families experience, families need access to a richer array of resources for protecting and providing for their children.

Parents who become involved with the child welfare system are more likely than others to experience poverty, substance abuse, mental health problems, inadequate housing, domestic violence, or a combination of these problems. Children are more likely to have emotional, behavioral, physical or other disabilities. Policies and services that help families address these conditions can in turn improve their capacity to meet their children's developmental needs.

Research has determined that investment in evidence-based support for families experiencing difficulty caring for their children helps to improve child safety and well-being. Access to assistance that strengthens the capacity of parents and other caregivers produces benefits that ripple through the lives of many children. With adequate public investment in the effective supports described in this section, families often are able to care for their children without further services, and child abuse, neglect and other negative outcomes are prevented.

1.1 Investment in evidence-based prevention.

Federal and state funding is tipped overwhelmingly toward remediation of family problems rather than prevention. Investing in services and supports for at-risk families and their children targets scarce resources to those most likely to need them. Focusing spending on research-informed practices improves the likelihood that these families will realize benefits. Specific goals, benchmarks and ongoing monitoring are necessary to begin shifting investment toward family-strengthening services that produce positive outcomes for children.

Requiring investment in evidence-based services. In 2003, the Washington State Legislature directed the Washington State Institute for Public Policy to examine the costs and benefits of prevention and early intervention programs for youth. The study concluded that some programs were effective both in improving outcomes for children and youth and in saving taxpayers' money. It recommended that policymakers invest in these research-driven, "blue chip" prevention and early intervention programs[6]. In 2005, the Legislature responded by requiring that priority be given to child welfare funding for evidence-based prevention and early intervention. (2005 Wash. Laws, SB 6090, Chap. 518)

Texas legislation requires the state child welfare agency to fund evidence-backed programs designed to ameliorate child abuse and neglect that are offered by community-based organizations[7]. The priority for funding is programs that target children whose race or ethnicity is disproportionately represented in the child welfare system. The legislation further requires the combination of funds across state agencies in order to prevent placement of children in foster care. (2005 Tex. Gen. Laws, SB 6, Chap. 268, Secs. 164, 170.)

Setting benchmarks for investment. In 2006, Connecticut lawmakers established the goal that, by 2020, at least ten percent of total recommended appropriations for relevant agencies be allocated to prevention services to promote the health and well-being of children and families. The legislation imposed reporting requirements for the governor, executive branch agencies and new Child Poverty and Prevention Council, including an annual prevention report within the governor's budget that indicates the state's progress toward the 2020 funding goal. (2006 Conn. Acts, HB 5254)[8]

Policy Options: States can promote investment in evidence-based prevention by adopting either or both of the following policies:

- Require investment in evidence-based or research-informed prevention and early intervention programs.
- Set targets for shifting resources from remedial services to preventive and early intervention services.

1.2 Home visiting programs.

By helping families with young children get off to the right start, home visiting programs have far-reaching benefits for positive child development, increased parenting capacity, and reduced child abuse and neglect. Documented impacts include reductions in the frequency and severity of child maltreatment; enhanced parent-child interaction, parenting capacity, and parental functioning; improved access to preventive medical care; enhanced child development; and early identification of developmental delays.[9] Investment in home visiting programs has been shown to reduce costs due to foster care placements, hospitalizations and emergency room visits, unintended pregnancies, and other more expensive interventions.[10]

A study of prevention and early intervention programs by the Washington State Institute for Public Policy found that some forms of home visiting programs that target high-risk and/or low-income mothers and children are also cost-effective, with a return on investment ranging from $6,000 to $17,200 per child.[11] Of all prevention and early intervention programs studied, the Nurse-Family Partnership, which features visits by a trained nurse from pregnancy through the child's first two years, produced the greatest cost savings. Controlled, randomized trials among low-income, racially diverse mothers demonstrated positive outcomes and cost benefits.[12] Home visitation programs offer a variety of voluntary services to pregnant mothers and to families with new babies and young children. Structured or informal visits in the family's home focus on topics such as:

- Positive parenting practices and effective discipline techniques,
- Child development,
- Maternal and child health,
- Prevention of accidental childhood injuries through the development of safe home environments,
- Establishment of social supports and networks,
- Availability and accessibility of social services and other assistance, and
- Advocacy to help the parent, child, and family obtain the assistance they need.[13]

Six national home visitation models that have been evaluated include: the Nurse-Family Partnership, Healthy Families America, Parents as Teachers, Parent-Child Home Program, Home Instruction for Parents of Preschool Youngsters (HIPPY), and Early Head Start.[14] Depending on the program model, visits may be provided by nurses, other professional service providers, paraprofessionals or trained volunteers. As programs have expanded and matured, they have found that training and professional development, supervision, and content development are critical to achieving positive outcomes for families.

Of 42 states responding to a 2001 survey regarding home visiting activities that was sponsored by the Commonwealth Fund, 37 states reported state-based programs, and three more states provided state-level assistance to help local visiting programs.[15]

Policy Options: States can authorize and fund home visiting services using 1, 2, or 3 of the following standards of eligibility:

- Home visiting services with evidence-based components are available from pregnancy until the child is at least two years of age.
- Home visiting services with evidence-based components are available statewide to all low-income mothers.

1.3 Parenting education and training.

The term "parenting training" is used to describe an array of services provided to improve parenting. With an estimated 800,000 families participating annually, parenting training is thought to be the single most commonly provided service for families. Services may be voluntary or court-ordered, and completion of a training program is often accepted by courts as evidence that parenting is improving. Participants often include:

- Families who have been reported to the child welfare system and investigated for child abuse and neglect, but screened out;
- Families involved with the child welfare system working to retain or regain custody of their children (family preservation or reunification); and
- Reunified, adoptive or guardianship families receiving post-permanency services to meet child-rearing challenges.[16] When they incorporate key components, parenting education and training programs are shown to improve parenting effectiveness and protective factors for children. Recent research found that programs with certain characteristics are successful in helping parents deal with child conduct problems, improving parenting behaviors, and reducing child behavioral difficulties, and that changes are retained over time.
  A study in Oklahoma of one model of parenting education and training, parent-child interaction therapy, revealed improved outcomes for physically abused children, much lower reoccurrence of harm, and cost effectiveness.[17]

Although parenting training is very common, an extremely small portion of programs have been evaluated, and only one percent of child welfare agencies require use of a specific program model.[18] Successful programs avoid a one-size-fits-all approach. Instead, they match parenting education with the developmental needs of children, tailor activities to problems identified by parents, and feature parent-child interaction. They also:

- Require completion of behaviorally specific homework each week,
- Require frequent behavioral practice during sessions,
- Monitor individual progress,
- Involve at least 15 hours of individual or 25 hours of group participation,
- Include relatively intense supervision, and [19]
- Include hands-on learning with the child.

Evaluated models include The Incredible Years Parents Management Training from the Oregon Social Learning Center, Parent Child Interaction Therapy used in Oklahoma, and Safe Care.[20]

Policy Options: States can promote the use of evidence-based parenting education and training by adopting one of the following policies (listed in order of increasing effectiveness):

- Require the use of evidence-based parenting education and training programs
- Require and monitor the use of evidence-based parenting education and training programs

1.4 Respite and short-term crisis care.

Respite care services provide temporary relief for caregivers in stressful situations by offering short-term care of children who have disabilities or chronic or terminal illnesses, who are at risk of abuse or neglect, or who have experienced abuse or neglect.[21] Crisis care services — often called emergency respite or crisis nurseries — are a unique form of respite offered any time of the day or night when families are facing a crisis and no other safe childcare options are available.[22] Respite care typically lasts from a few hours to a few weeks. Respite providers may be family members, friends or neighbors, community recreation programs, child care providers, home health aides, family resource centers, or community service providers.[23] Additionally, respite and crisis care providers may offer supports to minimize the likelihood of future crises, such as parenting training, referrals to other programs, and after-crisis services for children and parents.

Rigorous research documents the success of crisis respite services in protecting children and keeping families together. Control group studies show that children receiving short-term, crisis respite services experience fewer substantiated incidents of maltreatment, fewer placements in foster care, and fewer out-of-home placements due to emotional and behavioral disturbance.[24]

Some states include respite care as a component of support systems targeted specifically to kinship caregivers, foster parents, and adoptive parents. At least seven

states provide respite care to either all foster parents or those caring for children with special needs.[25] In Minnesota, adoptive parents are eligible for up to 504 paid hours of respite care per year.[26]

Caution is necessary, however. Over time, many child welfare agencies have come to rely on crisis shelters to house children who have been removed from their families when immediate placement with kin or a foster family is not available. In these jurisdictions, what was intended as short term respite care has come to be used as congregate care placements for children in the custody of child welfare agencies. Research shows that shelter and other congregate care for infants and toddlers is damaging to brain development, and several jurisdictions have prohibited placement of young children in crisis nurseries and shelters.[27] (See Policy 5.4 — Prohibition of congregate care for young children.)

Policy Options: States can authorize and fund respite care using 1, 2, 3, 4, or 5 of the following eligibility criteria for families experiencing stress in caring for their children:

- All parents and caregivers of children who have disabilities,
- All parents and caregivers of children at risk of abuse and neglect,
- All foster parents,
- All kinship caregivers,
- All adoptive parents of children who have been involved with the child welfare system.

1.5 Navigators to connect families with services.

Building on the well-documented success of health care navigators, emerging studies indicate that navigators also can help families obtain the assistance they need to effectively care for their children. Navigator programs help parents and other caregivers find their way through the complicated web of public and community service systems to access needed supports and resources. Through face-to-face and/or phone interaction, navigators educate parents about services that are available and help them gain access to assistance. Many jurisdictions are utilizing peer navigators, who are themselves current or veteran service consumers.

In other fields, navigator programs have been used to help individuals navigate cancer treatment, other medical care, long term care, vocational rehabilitation, and mental health treatment. Rigorous health care research has demonstrated that navigators can improve early intervention and treatment for patients, including those from low-income households and cultural or ethnic minorities.[28]

Less rigorous research has been conducted of navigator programs that support families experiencing difficulties caring for their children, but promising studies are emerging. A study of two Washington State pilot projects indicated that navigator services significantly reduced kinship caregivers' needs.[29] Both Ohio and New Jersey have statewide navigator programs to help kinship caregivers to access benefits and services. Based upon the success of these programs, $5 million per year is set aside for Kinship Navigator programs through The Family Connections grants recently authorized in the federal Fostering Connections legislation. This competitive grants program is accessible to state, local, and tribal child welfare agencies and non profits that work with children in foster care or kinship care.[30]

Vermont's 360 Project, which provides navigators for parents who have disabilities, reports that fewer than 5 percent of participating parents with developmental disabilities have had their parental rights terminated, compared to the estimated national rate of 50 to 80 percent.[31]

Policy Options: States can pursue either or both of the following options:

- Authorize and fund navigator services using either or both of the following eligibility criteria for caregivers:
  - All parents who have disabilities or whose children have disabilities
  - All kinship caregivers
- Encourage state, local and tribal child welfare agencies, as well as private agencies with experience working with child welfare families, to apply for funding through the Family Connections grants authorized through the Fostering Connections legislation.

1.6 Family economic supports.

Families whose children are at risk of child abuse and neglect often face serious financial challenges. In 1996, children living in families with less than $15,000 in annual income were 22 times more likely to be abused or neglected than children in families with incomes of $30,000 or more.[32] Policies that increase family economic success can directly impact families' capacity to help their children meet key physical, emotional, social and cognitive developmental milestones. A range of policies that help adult family members obtain family-wage jobs with benefits and accumulate assets are outlined in the Policy Matters publication, *Improving the Economic Success of Families.*

An estimated 70 to 90 percent of children who remain with their families while receiving child welfare services are members of families who qualify for and receive

cash assistance.[33] Special efforts are necessary to connect these families with financial success strategies and assistance. For example, the Effective Systems section of this report describes policies that support coordinated or integrated eligibility determination and application for benefits. In addition, comprehensive family assessments such as those conducted by the Illinois Department of Children and Family Services identify financial factors that challenge parents' capacity to care for their children, including parental unemployment and economic loss. The assessment provides information for tailoring a case plan that includes strategies for improving family economic well-being.[34] (See Effective Systems, Policy 9.1. Individualized and comprehensive assessments and planning)

Other strategies for connecting families involved with the child welfare system with economic supports were institutionalized by the El Paso County, Colorado, Department of Human Services. The Department developed a range of strategies for removing barriers between the child welfare program and Temporary Aid for Needy Families (TANF), including ensuring that every family coming to the attention of the child welfare program is screened for participation in the TANF program. Both child welfare and TANF staff work with families to help them obtain financial assistance if needed and to strengthen family earning capacity.

Policy Options: States can authorize and fund family economic supports using 1, 2, 3 or 4 of the following approaches:

- Assess economic needs of families identified by the child welfare system,
- Use flex funds to provide concrete assistance when other sources of support are not available.
- Facilitate application for financial assistance,
- Connect families with Temporary Assistance for Needy Families (TANF) and other programs that can help them achieve economic success.

Policy Area 1: Family Supports Summary of Policy Options

Policy Area	Key Feature
1.1 Investment in evidence-based prevention	**Promote investment in evidence-based prevention by adopting either or both of the following policies:** • Require investment in evidence-based or research-informed prevention and early intervention programs. • Set targets for shifting resources from remedial services to preventive and early intervention services.
1.2 Home visiting programs	**Authorize and fund home visiting services using 1, 2, or 3 of the following standards of eligibility:** • Home visiting services with evidence-based components are available from pregnancy until the child is at least two years of age. • Home visiting services with evidence-based components are available statewide to all low-income mothers.
1.3 Parenting education and training	**Promote the use of evidence-based parenting education and training by adopting one of the following policies (listed in order of increasing effectiveness):** • Require the use of evidence-based parenting education and training programs • Require and monitor the use of evidence-based parenting education and training programs
1.4 Respite and short-term crisis care	**Authorize and fund respite care using 1, 2, 3, 4, or 5 of the following eligibility criteria for families experiencing stress in caring for their children:** • All parents and caregivers of children who have disabilities, • All parents and caregivers of children at risk of abuse and neglect, • All foster parents, • All kinship caregivers, • All adoptive parents of children who have been involved with the child welfare system.
1.5 Navigators to connect families with services	**Identify funding for navigator services through the following options:** • Authorize and fund navigator services using either or both of the following eligibility criteria for caregivers: - All parents who have disabilities or whose children have disabilities - All kinship caregivers • Encourage state, local and tribal child welfare agencies, as well as private agencies with experience working with child welfare families, to apply for funding through the Family Connections grants authorized through the Fostering Connections legislation.
1.6 Family economic supports	**Authorize and fund family economic supports using 1, 2, 3 or 4 of the following approaches:** • Assess economic needs of families identified by the child welfare system, • Use flex funds to provide concrete assistance when other sources of support are not available. • Facilitate application for financial assistance, • Connect families with Temporary Assistance for Needy Families (TANF) and other programs that can help them achieve economic success.

Preserving and Reunifying Families

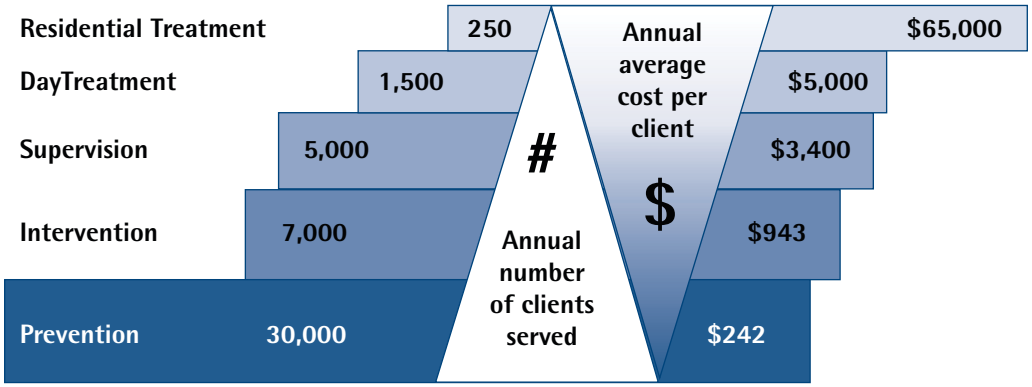
2 2.1 Inventory of services and resources to keep families together.

To ensure that the necessary array of services and supports are available for vulnerable children to thrive within their own families, policymakers need to inventory existing resources and determine whether services and funding are aligned with the desired outcomes. An accurate snapshot of state investments helps policymakers consider total state services and expenditures across programs, rather than examining individual programs in isolation. For example, an inventory might include services administered by the child welfare agency, the health or mental health system, the Medicaid program, domestic violence systems, education systems, housing authorities, and other entities.

Such an analysis allows decision makers to compare the state's investment in family preservation to spending for services provided out of home. An inventory and analysis of services and spending helps policymakers identify:

- gaps in evidence-based services,
- ways that available funds can be used more effectively to keep families safely together rather than apart,
- areas where funding can be redirected without causing harm, and
- services or strategies that require additional investment.

Probation Department, FY 2001–02 Estimated Costs for Juvenile Justice Continuum
(4,500 children and youth in custody)



Source: www.thechildrensinitiative.org/PDFa/Budget.pdf

Rather than a one-time exercise, ongoing monitoring of service availability, utilization, and investment is required. Policymakers can use many tools and processes for ensuring routine analysis and comparison of family preservation and out-of-home placement. While the most effective mechanism is likely to vary from state to state depending on the budget process, legislative structure, legislative-executive branch relationships, and other factors, it is critical that this analysis be incorporated into routine planning and budgeting.

Comparing utilization and funding for services to keep families together and for out-of-home placement. In Maryland, the legislative budget committees add language to the budget bill each year requesting the executive branch (specifically the Governor's Office for Children) to submit data regarding the number and costs of out-home-placements by local jurisdiction, reasons for new placements, family assessment data, number of children served and costs of family preservation, and child abuse and neglect reports during and after family preservation services. For 2005, there were 4,447 new entries in out-of-home care compared to 1,870 children served by interagency family preservation services — a ratio of 2.3 to 1.[37]

The following analysis from San Diego County, California, presents and compares expenditures for different types of services within one department and demonstrates that it is much more expensive to invest in restrictive and remedial programs than it is to support prevention efforts.[38] This same type of analysis could be conducted for state child welfare services and/or cross-system services.

Comparing cross-systems expenditures for children and families. A number of local jurisdictions (including Philadelphia, Seattle, and the California counties of San

Francisco, Contra Costa, Solano, and San Diego) have used children's budgets to identify different types of spending for children across agencies.[39]

Examining how expenditures align with desired outcomes. In Contra Costa County, the children's budget examines and compares the top 20 programs (including foster care) by gross expenditures. The budget is also organized to identify major expenditures that contribute to desired outcomes including family self-sufficiency, family safety, and children ready for school.[40]

Policy Options: States can mandate a comparison of expenditures for safely keeping families together versus expenditures for out-of-home placement at one of the following levels of organization (listed in order of increasing value for decision making):

- Within the child welfare system
- Within the child welfare system and across state agencies
- Within the child welfare system, across state agencies, and across other systems (such as juvenile justice and mental health)

2.2 Intensive family preservation and reunification services.

Family preservation programs that maintain a highly intensive service model are an essential component of an effective child welfare system.[41] For a number of reasons, repeated attempts to rigorously evaluate family preservation services have frustrated social scientists. The services are intended to reduce placement in foster care by strengthening the capacity of families to safely care for their children, but placement decisions are actually influenced by a complex array of factors that are difficult to measure. Variation among family preservation models and their implementation further complicate evaluation. In addition, the short-term, crisis intervention strategy is not intended as a stand-alone solution, and many experts consider the expectations for Intensive Family Preservation Services (IFPS) to be unrealistic for a single intervention. IFPS providers maintain that vulnerable families must be connected with ongoing community supports and even follow-up IFPS "booster shots."

Although family preservation services take many forms, intensive family preservation services (IFPS) incorporate specific elements designed to support families in crisis with children who are either at imminent risk of placement or in out-of-home placement:

- Immediate response within 24 hours,
- Accessibility of staff 24 hours a day, seven days a week,
- Small caseloads (two to four families),
- Intensive interventions (five to 20 hours per week as needed),

- Service delivery in the family's home and community,
  - Usually short-term services (four to eight weeks), to be followed by other support services,
  - Concrete services (such as health care, housing and other tangible services) and soft services (such as counseling and emotional support) delivered by the same worker,
  - Recognition of the importance of interaction between families and communities, and help for families to forge those links,
- Goal-oriented, "limited" objectives,
- Focus on teaching skills.[42]

One of the latest in a long string of studies, a 2006 meta-analysis of previous evaluations in 14 sites, demonstrated that IFPS programs adhering to the original and very intensive, Homebuilders™ model prevented out-of-home placement, reduced subsequent child abuse and neglect, and produced positive returns on public investment.[43] In addition to the Homebuilders model, an intensive, home-based reunification program that incorporates group work with parents and children and an innovative twice-weekly support group for parents has demonstrated higher reunification rates and shorter duration of out-of-home care.[44]

In 2006, the Washington State Institute for Public Policy reviewed randomized evaluation studies of IFPS programs and sorted the studies based on programs that incorporate the characteristics of the Homebuilders™ approach (listed above). The research concluded that these IFPS programs reduced out-of-home placement rates by an estimated 31 percent, while other programs did not significantly reduce placement. It also estimated that such programs produce $2.59 of benefits for each dollar of cost, based on reduction of placement (and associated costs) plus impacts on crime, high school graduation, K-12 grade repetition, test scores, and disordered use of alcohol and drugs resulting from abuse and neglect.[45]

In 2007, the National Family Preservation Network analyzed IFPS data from state or private contract agencies with well-defined program models in seven states (Colorado, Indiana, Maryland, Missouri, North Carolina, Pennsylvania, and Washington). Six of the seven sites offer both intensive family preservation and reunification services. The IFPS programs achieved a 93 percent placement prevention rate; at the conclusion of services, 85 percent of children were living with their biological parent, and the others were living with their adoptive parent or a relative. Although some service providers specialized or focused on cases involving particular types of maltreatment, placement prevention success did not vary significantly by type of maltreatment experienced. Families achieved substantial progress on several domains of family functioning, including the families' environment, parental capabilities, family interactions, family safety and child well-being. Intensive reunification services yielded positive, though

more mixed outcomes. Although local definitions of reunification varied among sites, 69 percent of families were reunited.[46]

In 2005, Maryland's Interagency Family Preservation Services and Department of Human Resources family preservation services reported that:

- Placement was avoided for 90 percent of participating children;
  - Environment, parental capability, family interaction, family safety, and child well-being improved for participants in the interagency services;
  - The cost/benefit ratio for the interagency services for FY03 was 1 to 8.4; for every $1 spent providing family preservation services, up to $8.40 in placement costs was avoided.[47]

Many states have legislation authorizing intensive family preservation services, and some specify intensive family preservation services. Washington State statutes require that IFPS incorporate many characteristics of the Homebuilders™ model.[48]

Policy Options: States can authorize and fund intensive family preservation services with evidence-based characteristics for the following (listed in order of increasingly broad impact):

- A limited number of families with a child at imminent risk of placement
- All families with a child at imminent risk of placement

2.3 "Flex funds" to support families in crisis.

"Flex funds" are relatively small amounts of funding available for workers to improve outcomes for individual children and families that are not subject to the usual, categorical restrictions. These funds enable caseworkers to keep families safely together by meeting the unique needs of individual children and families Flex funds can help strengthen or organize the family's natural system of supports, avoid out-of-home placement, reunify families, connect children in foster care with kin, or otherwise achieve positive child and family outcomes. Caseworkers are able to access flex funds for a variety of material needs, such as purchasing food or clothing; paying rent or utilities; buying furniture, baby supplies or cleaning materials; or repairing an automobile needed for transportation to a job. Examples of services purchased with flex funds include therapeutic services, mentoring for children or parents, specialized parenting training, independent living services, tutoring, and socially reinforcing activities.[49]

An evaluation of flex funds used by the Oregon State Office for Services to Children and Families found that they enabled children in out-of-home care due to poverty-related situations to return home sooner. Flex funds also contributed to improved child well-being in cases that were especially difficult and involved serious circumstances. Families rated services purchased with flex funds as more helpful than traditional services; community partners approved the public agency's ability to respond immediately and creatively to the needs of children; and caseworkers were convinced that the ability to individualize services was crucial to improving child and family outcomes. Caseworkers also reported that bureaucratic hurdles, delays, and inconsistent availability of funds could hinder the funds' effectiveness.[50]

Flex funds may be limited to a maximum amount per family, and approval by a supervisor or committee is usually required, especially if funds requested for a child or family exceed a specific amount. The Oregon State Office for Services to Children and Families limits annual per child payments to the equivalent of the basic foster care payment for two months. In Maryland, the Department of Human Resources annually budgets $10 million for flex funds that are allocated to local jurisdictions.

Policy Options: States can authorize and fund the use of flex funds using one the following funding standards (listed in increasing order of effectiveness):

- Flex funds available up to a fixed dollar amount per child or family.
- Flex funds for each child and family available at a level equal to the placement costs that can be avoided.

2.4 Shared Family Care.

Shared Family Care (SFC) is a promising alternative to foster care, especially for young children. It involves the placement of a parent (usually the mother) and at least one young child in the home of a community member who mentors the family while working with a team of professionals to help the family achieve safety, permanency and well-being goals. Participating families are at risk of having their children removed or are in the process of reunifying with them. Along with hands-on support and guidance from mentors, families receive comprehensive services from a team of professionals to meet their needs and increase their social and life skills, as well as help them connect to community resources for ongoing support.

Although control group studies have not been conducted, a quasi-experimental study found that SFC families re-entered foster care within one year at half the rate of families whose children were placed in traditional foster care. Three-quarters of participants were employed at graduation from the program compared to 36 percent at intake, and the average monthly income of participants increased from $520 at

intake to $1,100 at graduation. The overall cost of SFC is slightly more than basic foster care, but considerably less than treatment foster care.[51]

Researchers recommend more comprehensive studies of shared family care to determine the characteristics of families most likely to benefit, when shared family care should be offered, and details regarding the outcomes for participating children and parents.

Policy Options: States can authorize and fund shared family care using either or both of the following eligibility criteria:

- Shared family care is available as an alternative to out-of-home placement for families with a child at imminent risk of removal.
- Shared family care is available for reunification of families with a child in foster care.

2.5 Substance abuse treatment that allows children to stay with their parents.

Parental substance abuse is a serious threat to family stability and child well-being. State and local child welfare agencies estimate that up to 80 percent of the families on their caseloads have substance abuse problems — an assessment supported by 2008 national estimates that substance abuse was a factor in at least two-thirds of cases of children in foster care.[52] Research indicates that with adequate parental substance abuse treatment, parenting support, and case supervision, children may be better off with parents who have substance abuse problems than in out-of-home care.

A large body of research documents that substance abuse is a treatable public health problem with a wide range of cost-effective treatment solutions. At the same time, funding is seriously lacking for substance abuse treatment that can keep vulnerable families together.[53] Of the 13 to 16 million Americans who need alcohol and substance abuse treatment in any given year, only 3 million receive services. Among female substance abuse treatment clients who are parents, 44 percent reported they entered substance abuse treatment in order to retain or regain custody of their children.[54] However, a 1997 study found that child welfare agencies could provide treatment to less than one-third of parents who needed it.[55] Forty-six percent of parents with substance abuse problems involved with the child welfare system were neither offered nor provided substance abuse services.[56]

To safely preserve families with parental substance abuse problems requires a comprehensive policy approach that supports timely access to effective treatment.

A. Timely substance abuse treatment targeted to parents involved with the child welfare system. To help ensure that parents with substance abuse problems receive timely treatment needed to retain or regain custody of their children, state policymakers can target substance abuse treatment resources to this population and take steps to ensure access. Due to enormous unmet need for substance abuse services, parents with alcohol and other drug problems often face long waiting lists for treatment. Even when treatment is available, research shows that recovery takes time. Residential treatment programs usually recommend treatment for nine months or longer, and outpatient treatment requires at least six months. Studies indicate that the longer the treatment stays, the better the outcomes. In addition, treatment is not a one-time fix. There is a high probability of relapse, and repeat treatment must be available.

At the same time, long waits for admission to substance abuse treatment programs coupled with the long-term nature of effective treatment often require more time than federally mandated timelines for termination of parental rights allow. The federal Adoption and Safe Families Act (ASFA)[57] requires courts to make a decision regarding a child's permanent placement within 12 months after the child enters foster care, and states must initiate proceedings to terminate parental rights after a child has been in foster care for 15 of the most recent 22 months (unless the case plan documents a compelling reason that filing a petition to terminate parental rights would not be in the best interest of the child).

Legislation in Ohio (Ohio Rev. Code Ann. Sec. 340.033) and New York (1999 N.Y. AB 7938) requires local boards and the state respectively to provide admission priority to drug, alcohol, and substance abuse treatment to parents whose children are in foster care or in jeopardy of placement.

B. Collaborative approaches to assess and facilitate access to substance abuse treatment for parents. Successful models of substance abuse treatment for parents with children at risk often hinge on collaboration among substance abuse, child welfare, and other professionals. Mental health treatment is necessary for many individuals with substance abuse problems. Others experience health problems (such as HIV/AIDS), domestic violence, and/or housing issues that require a collaborative response.[58]

The Effective Systems section of this report includes a set of policy tools that support interagency collaboration and service delivery. (See Policy Area 14: Effective Systems, Interagency Collaboration) This section outlines policies that promote collaborative approaches to assessment of parental substance abuse problems and access to treatment.

As part of a federal Title IV-E waiver demonstration of substance abuse treatment for families involved with the child welfare system, Delaware tested the use of multidisciplinary teams and compared outcomes with families who did not have

the benefit of a team approach. In each of three counties, a substance abuse liaison assisted child welfare workers to identify families in need of substance abuse services, assess their treatment needs, link them with appropriate services and provide case management. Children in participating families spent 34 percent fewer days in foster care, more cases were closed due to completion of case plans and risk reduction, and the average cost of foster care in the demonstration group was $11,736 compared to $18,149 in the control group. Over more than two years, foster care costs for families with substance abuse problems decreased by 18 percent, while costs for the control group families increased 25 percent.

In Jacksonville, Florida, alcohol and other drug counselors are stationed with child protective services investigation units to assist with assessing parents' substance abuse problems, referring them to services, and encouraging parents to participate in treatment.[59]

C. Residential substance abuse treatment programs that allow children to stay with their parents. Comprehensive residential programs that allow women to keep their children with them during treatment demonstrate positive outcomes for the mothers and children, and promise long term savings for taxpayers. A study of 50 federally-funded residential treatment programs that allow children to stay with their mothers reported impressive reductions in women's use of alcohol and drugs (including crack cocaine, methamphetamine, and heroin). The findings showed that among pregnant participants, substance abuse was lower than the rates reported for U.S. women in the general population.[60] Furthermore, the programs were able to overcome a major barrier to treatment success by engaging parents in services; almost half of the clients in residential treatment said they would not have entered treatment if they had not been able to bring their children with them.[61]

Mothers in residential treatment with their children are over five times more likely to live with all their children after discharge than women who did not co-reside with their children during treatment.[62] Other results documented for these programs include improvements in children's behavioral and emotional functioning, more positive family relationships, reduced parental stress, and increases in the positive social networks that provide protective factors for children.[63] Long-term savings are predicted from avoided medical treatments, child health care, welfare, and criminal justice system involvement.[64]

Although some programs limit the number and ages of children co-residing with their mothers, the 50 programs in the federal study did not. When possible and appropriate, the children's fathers were included in the treatment protocol as well. Successful programs are relatively long term (generally six to twelve months); provide gender-specific, culturally appropriate services; feature comprehensive

services that are tailored to each family; and assist with transition to the community. The comprehensive array of services often includes:

- health care, including pre-natal and pediatric care, medical treatment, and nutrition services;
- mental health treatment including individual, group and family therapy, as well as play therapy and services to address children's behavioral problems;
- parenting training, support, and supervision;
- vocational training, life skills education, and legal services;
- early care and education, on-site education or coordination with community schools, and recreation for school-aged children.

Family residential substance abuse treatment programs are one of the major activities allowable under new federal Family Connections grants, authorized through the Fostering Connections legislation. The program authorizes $15 million a year for competitive, matching grants to state, local or tribal child welfare agencies and nonprofit organizations that have experience working with children in foster care or kinship care.[65]

Policy Options: States can authorize and fund substance abuse services using 1, 2, or 3 of the following policies:

- Parents with a child at risk of placement or in foster care have priority for substance abuse treatment;
- State supports a team approach that includes child welfare and substance abuse professionals to identify and assess substance abuse problems of families referred for child abuse or neglect and to facilitate timely access to treatment;
- Evidence-based, in-patient substance abuse treatment that allows children to remain with their parent(s) is made available.

2.6 Home and community-based services for families and children with mental illness

Parents with Mental Illness. Mental illness can cause mild to severe disturbances in thought and behavior and can have a significant impact on family stability and parenting capacity. In New York, 16 percent of families involved with the foster care system and 21 percent of those receiving family preservation services include a parent with mental illness. As many as 70 percent of parents with mental illness are estimated to lose custody of their children — sometimes due to the stigma of mental illness, rather than untreatable conditions that cause actual harm.[66]

Children whose parents have a mental illness are at risk of developing social, emotional, and/or behavioral problems, although their risk of child abuse and neglect or removal from the home is not clearly documented or understood. In a 2000 survey by the Child Welfare League of America, fewer than a third of states were able to say whether parental mental health was the primary reason for a child's placement.[67] The overall impact of parental mental illness on children depends on the severity of a parent's mental illness and the extent of the symptoms. In many families, the effect of a parent's mental illness is compounded by other risk factors, such as poverty, lack of employment, housing problems, and substance abuse. The lack of protective factors, such as the absence of other competent adults in the household, compounds the risks to child well-being.[68] One study found that nearly 25 percent of caseworkers for mentally ill adults had filed reports of suspected child abuse or neglect concerning their clients.[69] Most state laws include mental illness as a factor to be considered when determining parental fitness, though mental illness alone is not sufficient to lead to loss of child custody or grounds for termination of parental rights.

Despite the prevalence of both mental illness among American adults and parenthood among those adults, few programs or services are available to meet the needs of parents and their children. A national survey of state mental health agencies indicated that those agencies have become less responsive over the past 20 years to adults who are parents.[70] Existing treatment largely focuses on individuals, rather than families. Although psychiatric rehabilitation strategies have been shown to be effective in improving the functioning of adults with mental illness, their role and functioning as parents has been largely ignored. In addition, the stigma of mental illness compared to other disabilities and fear of losing custody of their children keep many parents from seeking help.

Children with Mental Health Problems. Research indicates that between one-half and three-fourths of the children entering foster care exhibit behavior or social competency problems that warrant mental health care.[71] Half of the children in foster care have problematic adaptive functioning scores, behavioral problems, or developmental problems. Forty percent of children in foster care between the ages of 6 and 17 are diagnosed with a moderate impairment of some type.[72] At the same time, the degree to which mental health problems lead to, contribute to, or result from foster care placement is not known. Many experts postulate that children's behavioral, emotional and mental disorders are among a constellation of factors that place them at risk of out-of-home placement.

Young people with mental health disorders fare better at home, in school, and in their communities when they receive appropriate treatment. Yet, services to evaluate and treat mental health problems of children and youth, as well as resources and

supports to help their families care for them, are severely lacking. It is estimated that 75 to 80 percent of children and youth who need mental health services do not receive them.[73] Children who are uninsured and Latino children are especially likely to go un-served.[74] Indeed, significant disparities in mental health service utilization have been documented for children of color prior to child welfare placement, in court-ordered services, and post-placement.[75] These disparities are likely to contribute to racial disproportionality within the child welfare system.

Thousands of parents — unable to obtain appropriate and affordable mental health treatment for their children and often facing related financial and personal crises — find themselves compelled to relinquish custody to gain access to services.[76] Custodial relinquishment occurs when parents voluntarily transfer legal custody of a child to the state. In response to a 2000 Child Welfare League of America survey, more than half the states reported that parents relinquish custody to access mental health services, but they were unable to report how often this occurs. Through a survey of child welfare directors in 19 states and juvenile justice officials in 30 counties, the GAO estimated that more than 12,700 children had been placed in these systems to obtain mental health services. However, because the study did not include the five states with the highest child populations, this number greatly understates the problem.[77] A 2005 report commissioned by the Virginia General Assembly found that one in four children in the Virginia foster care system was there to receive mental health treatment for severe emotional disturbance.[78] Once a child with mental health issues enters the child welfare system, he/she is less likely than others in foster care to achieve permanency and more likely to experience restrictive and costly placements such as hospitalization or residential treatment.[79]

A range of policy strategies are required to prevent custodial relinquishment to obtain mental health services, other unnecessary placement of children with mental health disabilities, and the disruption of families due to parental mental illness.

A. Evidence-based, home and community mental health services. Family-based treatments, which engage parents as primary participants in the treatment process for children and youth have been the subject of numerous clinical trials over the past ten years. A synthesis of this research shows family-based treatment is effective in improving a range of child and adolescent substance abuse problems as well as behavioral and mental health disorders. Family involvement can lead to "better treatment engagement, retention, compliance, effectiveness, and maintenance of gains."[80] Two types of evidence-based mental health treatment address mental health problems among children in youth:

- Cognitive Behavioral Therapy (CBT) is a tested treatment that improves anxiety, depression, and if parents are involved, helps reduce disruptive behaviors,

ADHD, and possibly post-traumatic stress disorder. The approach works with a variety of ages.[81]

- Multi-systemic Therapy (MST) is an intensive, short-term (three to four months), home- and family-focused treatment approach for youth with severe emotional disturbances. MST intervenes directly in the youth's family, peer group, school, and neighborhood by identifying and targeting factors that contribute to the youth's problem behaviors and developing skills in both parents and community organizations. MST has been established as effective in randomized clinical trials for youth in the juvenile justice system. Initial results are positive for other populations of youth receiving MST instead of psychiatric hospitalization, including abused and neglected youth and children in psychiatric inpatient facilities.[82]

A small number of promising, though not rigorously evaluated, programs specializing in supporting parents with mental illness and their children have developed in the U.S. and other countries. The Invisible Children's Project is a model program for parents with mental illness and their children that started in Goshen, New York and is being replicated across the country. Many participating families are at risk for having their children placed in foster care, and keeping their families together is often participants' primary goal. The comprehensive program includes access to 24-hour family case management, support for housing, respite child care, planning in the event of parental hospitalization, advocacy with schools, social services, family court collaboration, parenting training, vocational training, educational support, in-home clinical services, information, referrals, linkages to the community, budget counseling, recreational family activities, and more. Although the program has not been evaluated using scientifically rigorous methodology, internal studies found a decrease in the number of children placed in out-of-home settings, including foster care. The data further indicate that the Invisible Children's Project is particularly effective in helping participants parent more effectively. Child protective services workers stated that children were returned home or maintained in the home as a direct result of the Project involvement.[8]

B. Comprehensive systems of care for children and parents suffering from mental illness and behavioral disorders. Investment in family and community-based systems of care — comprehensive approaches for meeting the needs of children, youth and adults who have mental health disorders — combines a range of resources and strategies that help prevent out-of-home placement. While these systems of care are not part of the traditional child welfare system, the safety and well-being of children affected by mental illness who come to the attention of child welfare agencies depend on their effectiveness.

Coordinated systems of care feature a range of intervention strategies and services that can be customized to increase positive outcomes for individual children in the care of their parents. Regardless of individual needs, the focus is on the family as a whole — both to provide the care that children with disabilities need and to assist parents with mental illness in parenting their children. In addition to the inpatient treatment approaches that characterize most mental health systems, systems of care feature a continuum of in-home and community-based supports, including:

- Assessment of parenting strengths, needs and goals
- Early and periodic assessment of children
- Comprehensive case management
- Peer support and self-help
- Mentoring and supports for parents
- Child development and parenting skills training
- Assistance with school issues
- Medication management
- Crisis and respite care
- Trauma counseling
- Substance abuse treatment[84]

In addition, systems of care are characterized by multi-agency partnerships that include mental health treatment professionals, child welfare workers, early care providers, teachers, health care providers, and other service providers working together to ensure that protective factors help mitigate the risks that children and families face. Wraparound services which are designed and implemented on an interagency basis and depend on flexible, non-categorical funding provide assistance tailored to the individual child and family.

According to the U.S. Department of Health and Human Services (DHHS) Substance Abuse and Mental Health Services Administration (SAMHSA), communities in at least 42 states have developed systems of care initiatives to build community treatment for children with serious emotional disturbance. Wraparound Milwaukee is a coordinated system of community-based care and resources for families of children with severe emotional, behavioral, and mental health problems. Features include a provider network that furnishes an array of mental health and child welfare services; an individualized plan of care; a care coordinator management system to ensure that services are coordinated, monitored, and evaluated; a Mobile Urgent Treatment Team to provide crisis intervention services; a managed care approach including preauthorization of services and service monitoring; and a reinvestment strategy in which dollars saved from decreased use of inpatient or residential care are invested in increased service capacity."[85] For 267 children completing the program and exiting Wraparound Milwaukee in 2005, 92 percent achieved the permanency goal in their care plan. This included 75 percent of children returned to their own homes.[86]

Wraparound in Nevada for Children and Families (WIN) focuses on children with severe emotional disturbance who are in the care or custody of a public child welfare agency. WIN provides intensive clinical case management that supports a comprehensive system of care for these children, many of whom come from families who struggle with complex personal challenges in addition to difficulties keeping their children safe and free from harm. Of more than 600 children served by WIN, 43 percent of those discharged were returned to their family homes, usually with ongoing in-home and community services.[87]

Policy Options: States can authorize and fund home and community-based services in accordance with either or both of the following service delivery standards:

- Evidence-based treatment programs for children, youth and parents with mental health problems are available within the child's home and community as an alternative to out-of-home treatment.
- The state invests in supporting a statewide, community-based system of care that includes a range of services and supports for children and parents involved with the child welfare system when there is risk of out-of-home placement.

2.7 Supportive housing programs.

Safe, affordable housing accompanied by other supports can both prevent foster care for a growing number of children and reunify as many as 30 percent of children in care with their families.[88] Research has documented that families who experience homelessness have an increased risk of involvement in the child welfare system. One study found that homeless women had almost seven times greater risk of child welfare involvement than non-homeless women and almost nine times the risk that one or more of their children would be placed in out-of-home care.[89] Inadequate housing is the primary reason for 10 to 30 percent of foster care placements — a poor response to homelessness and other family housing problems that often result from family economic crises and domestic violence.[90]

Housing assistance and supportive services for families are a cost-effective alternative to out-of-home placement. The average cost of housing and support services for families is estimated to be 70 percent less than the cost of foster care, resulting in savings nationwide of $1.94 billion per year ($31,964 per family).[91] However, a federal study found that only one in 50 primary caregivers for children in foster care received temporary shelter or a housing payment and only five percent received housing.[92] African American families needing housing are even less likely than whites to receive the services.[93]

Supportive housing programs represent a growing gap in the resources that families need to care for their children. While these services have been shown to be effective in preserving and reunifying families, their availability is severely limited by lack of federal, state and local investment. Portable vouchers, widely considered to be the most effective and low-cost approach to expanding affordable housing in desirable neighborhoods, are provided by the federal government through the Housing Choice Voucher (formerly Section 8),[94] Unfortunately, in 2003 three-quarters of eligible households were unable to receive these vouchers due to lack of funding.[95]

In 1990, Congress authorized the Family Unification Program, a HUD-administered program that targeted low income families with inadequate housing who had been separated or who faced separation from their children and to youth aging out of foster care. This successful program provided housing vouchers as well as support services such as food, counseling, health services, mental health care, financial education, and employment services.[96] The program awarded 39,000 housing vouchers and is credited with allowing more than 100,000 children to return home from foster care or avoid out-of-home placement.[97] Evaluation of the program found that up to 62 percent of the separated families had all of their children returned to them and 90 percent of the at-risk families were able to keep all of their children.[98] In 2008, HUD announced $20 million in new federal housing certificates for child welfare involved families and youth aging out of foster care.[99]

Examples of state programs that have utilized the federal Family Unification Program resources included the Utah Family Reunification Project, which provided an array of intensive in-home services to parents of children in out-of-home care including food, housing and employment. Evaluation found that participating families were more likely to be reunified, were more successful in keeping their children in-home following reunification, and received reduced supervision by the child welfare agency.[100]

The Supportive Housing for Families Program of Connecticut is a collaborative public-private initiative that combines state funding with federal housing vouchers to provide supportive services and permanent affordable housing to families involved with the State child welfare system who are at risk of separation or who have been separated. Program components include permanent housing, home-based intensive case management (ICM), and services tailored to fit each family's care plan, such as substance abuse treatment, parenting training, child care, transportation and educational and vocational training. ICM may last up to 2 years, and it serves as the single point of accountability for coordination of appropriate services to accomplish the family plan. The Department of Children and Families (DCF, the state child welfare agency) uses state dollars to fund services, and the Department of Social Services funds housing through federal vouchers. The Connection Inc., a non-profit human service and community development agency, operates the program and,

along with nine additional community-based, non-profit agencies, provides ICM statewide. In the program's first six years, 455 families were housed and over 1,130 children were reunified or preserved with their families. Seventy-three percent of families met the goals identified in their case plan and had their DCF case closed.[101]

Policy Options: States can authorize and fund supportive housing programs using one or both of the following eligibility criteria:

- Supportive housing programs are available to families with a child at risk of out-of-home placement due to inadequate housing.
- Supportive housing programs are available to reunify families with a child in foster care due to housing problems.

2.8 Removal of the perpetrator in cases involving domestic violence.

Children in homes where domestic violence occurs are more likely to experience child abuse and neglect. Extensive research shows at least a 40 percent co-occurrence, and several studies indicate that children in homes where adult domestic violence occurs are at greater risk of physical abuse in particular. In addition, children witnessing domestic violence experience recurring emotional trauma. At the same time, many adult victims are effective parents and are able to mediate the effect of their children's exposure to domestic violence.[102] Clearly, one of the best ways to keep children safe is to keep their parents (or battered parent) safe. Although there are no studies of the outcomes for children, it is the consensus of domestic violence, judicial and child welfare experts that when domestic violence places a child and parent at risk, removal of the perpetrator can help to protect the victimized parent and allow the child to remain in the home.

A. Removing the perpetrator. California legislation requires the courts in child abuse and neglect cases to consider ordering the violent parent to leave the home instead of removing the child. Alaska statutes require the state child welfare agency to make efforts to protect the child and prevent separation of the child from the battered parent, and to remove the batterer from the home.[103] In 2001, the Florida Legislature directed that training for child protective services staff include instruction for removing a perpetrator of domestic violence from the home.[104]

B. Restraining orders that protect children. All states have processes for victims of domestic violence to obtain restraining orders, which compel a violent partner to stay a specified distance away from the victim and his/her home, but state laws vary regarding the duration and scope of restraining orders. For example, in California,

restraining orders can protect children and other family or household members as well as the victim him/herself, can last up to three years, and can include additional provisions such as mandated treatment for the abuser.[105]

At the same time, restraining orders will help keep children safe only if they are accessible and enforceable. Alaska, Indiana and South Dakota statutes allow restraining orders against perpetrators of domestic violence to be issued in child welfare cases instead of requiring the nonviolent parent to file a separate legal action. California child welfare agencies are required to assist battered parents in obtaining restraining orders and other services and supports.[106]

Policy Options: States can promote removal of the perpetrator in cases involving domestic violence by adopting 1, 2, 3, or 4, of the following policies:

- Legislation requires the court to consider removal of the perpetrator as opposed to the child.
- Restraining orders can include children as well as the adult victim of domestic violence.
- Restraining orders may be issued as part of child protection proceedings.
- The child welfare agency must provide assistance in obtaining restraining orders.

Policy Area	Policy Options
2.5 Inventory of services and resources to keep families together	Mandate a comparison of expenditures for safely keeping families together versus expenditures for out-of-home placement at one of the following levels of organization (listed in order of increasing value for decision making): • Within the child welfare system • Within the child welfare system and across state agencies • Within the child welfare system, across state agencies, and across other systems (such as juvenile justice and mental health)
2.6 Intensive family preservation and reunification services	Authorize and fund intensive family preservation services with evidence-based characteristics for the following (listed in order of increasingly broad impact): • A limited number of families with a child at imminent risk of placement • All families with a child at imminent risk of placement
2.7 Flex funds" to support families in crisis	Authorize and fund the use of flex funds using one the following funding standards (listed in increasing order of effectiveness): • Flex funds available up to a fixed dollar amount per child or family. • Flex funds for each child and family available at a level equal to the placement costs that can be avoided.
2.8 Shared family care	Authorize and fund shared family care using either or both of the following eligibility criteria: • Shared family care is available as an alternative to out-of-home placement for families with a child at imminent risk of removal. • Shared family care is available for reunification of families with a child in foster care.
2.9 Substance abuse treatment that allows children to stay with their parents	Authorize and fund substance abuse services using 1, 2, or 3 of the following policies: • Parents with a child at risk of placement or in foster care have priority for substance abuse treatment; • State supports a team approach that includes child welfare and substance abuse professionals to identify and assess substance abuse problems of families referred for child abuse or neglect and to facilitate timely access to treatment; • Evidence-based, in-patient substance abuse treatment that allows children to remain with their parent(s) is made available.
2.6 Home and community–based services for children and parents with mental illness	Authorize and fund home and community-based services in accordance with either or both of the following service • delivery standards: • Evidence-based treatment programs for children, youth and parents with mental health problems are available within the child's home and community as an alternative to out-of-home treatment. • The state invests in supporting a statewide, community-based system of care that includes a range of services and supports for children and parents involved with the child welfare system when there is risk of out-of-home placement.

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Policy Area 2: Preserving and Reunifying Families Summary of Policy Options

Policy Area	Policy Options
2.7 Supportive housing programs	Authorize and fund supportive housing programs using one or both of the following eligibility criteria: • Supportive housing programs are available to families with a child at risk of out-of-home placement due to inadequate housing. • Supportive housing programs are available to reunify families with a child in foster care due to housing problems.
2.8 Removal of the perpetrator in cases involving domestic violence	Promote removal of the perpetrator in cases involving domestic violence by adopting 1, 2, 3, or 4, of the following policies: • Legislation requires the court to consider removal of the perpetrator as opposed to the child. • Restraining orders can include children as well as the adult victim of domestic violence. • Restraining orders may be issued as part of child protection proceedings. • The child welfare agency must provide assistance in obtaining restraining orders.

Lifelong Family Connections

3

Connections with relatives and other adults with whom a child has a significant emotional relationship (fictive kin) are critical to a child's sense of identity and a cornerstone of emotional and social development. Relationships with family members help children develop and retain a sense of connection with their racial, ethnic, cultural, linguistic, and religious or spiritual heritage. In many cultures, the child's very identity may be defined by connections to relatives, godparents and other family friends, clan, and tribe, and it is common practice for members of the kinship network to be an active, continuous, and permanent part of the child's life. In addition, relatives and other adults with strong emotional connections are important members of a child's safety net and sources of emotional and physical nurturing.

Children and youth who have been removed from their parents and other family due to child abuse or neglect report broken family connections leave them feeling alone and confused about their identities. When children in out-of-home care run away, they usually run home to a family member due to the distinct emotional connection they feel with their birth families and their urge to reconnect or to remain connected.[107] A large study of foster care alumni found that almost all the young adults had maintained at least some family ties, often despite many years in foster care, and 77 percent reported feeling very close to a family member, especially a sibling.[108] In addition, a growing body of rigorous research and evidence from the field reports the benefits for vulnerable children who can thrive within their own homes or alternatively be raised by willing and able kin.[109]

Connections with kin also are a crucial strategy for reducing racial disproportionality within the foster care and larger child welfare system. Beyond reducing disproportionality, kinship connections can help to improve a broad array of outcomes for children and families of color.

To strengthen lifelong family connections and the benefits of familial relationships for vulnerable children requires a continuum of ongoing efforts. Policies throughout this report help to build that continuum.

The first priority is strengthening and preserving birth families, so children can be safe and thrive without experiencing the harm of separation. (See Policy Area 1, Family Supports and Policy Area 2, Family Preservation and Reunification) Kin often help prevent out-of-home placement by providing respite care, financial assistance, and other support for parents striving to care for their children. If a child must be removed from his or her family, the goal is to reunify the family as quickly as it is safe and possible. (See Policy Area 2, Family Preservation and Reunification.) Here again, the extended family can assist in planning for the child's safety and development because they often contribute important information and perspectives about the child's and parents' strengths and needs, the child's cultural heritage and practices, and potential sources of support. Strong emotional and familial bonds make kin the first resource of choice when a child is unable to remain with his or her parents, even temporarily. (See Policy Area 4, Supports for Kinship Caregiving.) Kinship care includes both:

- "Informal" kinship care when a relative or other adult with close emotional ties assumes physical custody of the child without involvement of the child welfare system or without transferring legal custody to the child welfare agency, and
- "Formal" kinship care or kinship foster care when a relative becomes a licensed foster parent.

Children placed in relative foster care experience a number of advantages compared to children in non-relative care, including the likelihood that they will be placed with their siblings — yet another way to maintain family connections. For children in out-of-home placement, frequent and meaningful contact with siblings, parents and other kin helps to sustain family relationships and often aids in successful reunification.

When a child cannot be reunified safely with his or her parents, a home with caring, willing and able kin is the preferred option for legal permanency, either through adoption or permanent legal guardianship. (See Policy Area 4, Support for Kinship Caregiving.) Transfer of legal custody to kin helps to ensure that the child's familial ties will be life long. Ensuring that no child leaves foster care without ongoing connections with kin is one part of a complete strategy for a successful transition

to adulthood for the 20,000 children who age out of foster care each year.[110] (See Policy 8.6, Youth in Transition to Adulthood, Permanent connections to caring kin.)

3.1 Location and engagement of kin.

Policies that require diligent or reasonable efforts to identify, locate and engage kin are critical to ensuring lifelong family connections for children involved with the child welfare system. These efforts are the first step to exploring the roles that caring adults can have in the lives of vulnerable children. Not only do caring kin offer invaluable resources to children, according to international humanitarian law referenced in the Geneva Convention, relatives have a right to know that a member of their family network needs help. Pioneers of a growing body of practice in locating and engaging relatives of children involved with the child welfare system report that the typical American child living in out-of-home care has 100 to 300 living relatives and that usually some kin are willing and able to provide emotional and/or other support for the child.[111] While internet search technology has boosted the ability to locate kin, this is only one step in engaging kin and ensuring permanent connections for children.

The Fostering Connections legislation has three provisions that support location and engagement of kin. They include:

- Requires states to exercise due diligence to identify and provide notice to all adult grandparents and other adult relatives of a child within 30 days after the child is removed from his or her home.
- Allows child welfare agencies to directly access the Federal Parent Locator Service to help locate children's parents and help them find relatives; and
- Authorizes competitive Family Connections grants through which intensive family finding is one of the allowable activities under the grant program.[112]

State policies that build on the federal provisions and help to ensure effective relative location and engagement of kin contain several key components:

Ongoing search for relatives, including absent parents, is required from the time of the child's initial contact with the child welfare system to permanency. While federal statute requires efforts to locate and identify relatives within 30 days of a child's placement, state policies can reinforce the importance of on-going and continuous search to unearth as much support possible for the child.

In Washington State, the child welfare agency may conduct a relative search at any and all of the following times:

- Original placement,
- Family team decision meetings,
- Shared planning meetings (permanency planning meetings or any staffing),
- Anytime a placement changes or staff have any contact with child/family,
- When a case file is reviewed.

Contacting absent parents (usually fathers) only when a decision has been made to terminate parental rights is a great disservice to both children and their parents. The New York State child welfare agency has developed policy and protocol aimed specifically at locating and engaging absent parents as early as possible.[113]

Washington recently passed a law that requires social workers, the courts and all other service providers to inquire about a child's family in an effort to identify and locate family members at every stage of a foster-care case. The law has demonstrated some success, doubling the number of children in relative placements as opposed to foster care over a two year time period (from 19 percent to 37 percent).

Reasonable or diligent search efforts to locate relatives are required. State statutes of California, Colorado, Florida, Georgia, Minnesota, and Washington provide a standard for action by specifically mandating the public child welfare agency to make diligent or reasonable efforts to locate kin as possible placement resources. Utah law allows the court to order a reasonable search. Florida law requires that, if the court does not commit a child to the temporary legal custody of a relative, legal custodian, or other adult willing to care for the child, the disposition order must state the reasons for the decision.[114]

Court determination of diligent or reasonable efforts is required. California, Florida and New York provide court oversight by requiring a court determination of whether the child welfare agency made diligent efforts to locate kin.[115]

Documentation of search efforts is required. By documenting actions to locate and engage relatives, child welfare agencies not only provide evidence of the diligence of their search; a record that can help connect children with kin in the future is preserved. Documentation requirements are usually specified in agency policy.[116]

Policy Options: States can promote the location and engagement of kin by adopting 1, 2, 3, or 4 of the following policies:

- Reasonable or diligent efforts to locate and engage kin are required.
- Court determination of reasonable or diligent search efforts is required.
- Immediate and ongoing search efforts are required.
- Documentation of search efforts and review of that documentation is required.

Policy Options: States can require grandparent notification by adopting one of the following policies (listed in order of increasing timeliness):

- Grandparent notification is required within 60 days.
- Grandparent notification is required within 15 days.
- Grandparent notification is required at the time of placement.
- Grandparent notification and information about options for relative care is required before placement of a child in state custody.

3.2 Family visitation for children in foster care.

Requiring quality, face-to-face contact between parents and their children in foster care is a crucial way to maintain family connections and promote timely reunification. The primary goal of scheduled visitation between parents and their children in foster care is the maintenance of parent-child and other family attachments and reduction in children's sense of abandonment. Researchers have found that parent-child visiting has positive impact on children's well-being while in care, length of stay in care, and placement outcomes, particularly family reunification. A study of children 12 years old or younger who entered foster care concluded that when mothers visited frequently the child was ten times more likely to be reunified.[117] Children of incarcerated parents are especially vulnerable to issues of abandonment, separation anxiety, and trauma — in large part due to prolonged and limited access to their parents.

Effective child welfare agency policies define the issues that must be considered when developing a parent-child visitation plan, including who participates, where and when visits occur, and visitation rights and responsibilities. Frequent, quality child-family visitation must be facilitated at convenient times including nights and weekends and at community-based, family-friendly locations. More than half of the 37 state agencies that responded to a survey on visitation policies identify where visits should take place. Consistent with evidence regarding effective visitation, they emphasize the importance of visiting in the least restrictive, most homelike setting possible.

When family reunification is the goal, Illinois policy prioritizes visitation in the family home. Illinois and Massachusetts also provide visitation in early childhood care and education settings. Oregon's policy requires that consideration be given to the child's school schedule and to the parents' work and treatment obligations.[118]

Enhanced visitation programs are especially important for reducing the negative impacts of parental incarceration. The Family Reunification Program is a collaborative effort among St. Rose Youth & Family Center, Inc. (a nonsectarian, nonprofit organization), the Bureau of Milwaukee Child Welfare, six Wisconsin correctional institutions, and other state and local agencies. Components include

regular parent-child visitation with transportation for children to and from prison facilities where parents reside; age-specific support groups for children conducted after each visit; facilitated support groups for incarcerated parents to discuss issues raised through visitation; and a Girl Scout program that "bonds" together girls and their incarcerated mothers through scouting activities.[119]

Policy Options: States can promote family visitation by adopting 1, 2, 3, 4, or 5 of the following policies:

- Visitation is provided at times convenient to the child and parents' schedules.
- Visitation is provided within other family friendly settings
- Visitation is provided within early childhood care and education settings
- Visitation is provided for all children in foster care with incarcerated parents at family-friendly settings within correctional facilities and supplemented by specialized supports
- State has standards of minimal weekly visitation between children and parents.

Policy Area 2: Preserving and Reunifying Families Summary of Policy Options

Policy Area	Policy Options
3.1 Location and engagement of kin	**Promote the location and engagement of kin by adopting 1, 2, 3, or 4 of the following policies:** • Reasonable or diligent efforts to locate and engage kin are required. • Court determination of reasonable or diligent search efforts is required. • Immediate and ongoing search efforts are required. • Documentation of search efforts and review of that documentation is required. **Require grandparent notification by adopting one of the following policies (listed in order of increasing timeliness):** • Grandparent notification is required within 60 days. • Grandparent notification is required within 15 days. • Grandparent notification is required at the time of placement. • Grandparent notification and information about options for relative care is required before placement of a child in state custody.
3.2 Family visitation for children in foster care	**Promote family visitation by adopting 1, 2, 3, 4, or 5 of the following policies:** • Visitation is provided at times convenient to the child and parents' schedules. • Visitation is provided within other family friendly settings • Visitation is provided within early childhood care and education settings • Visitation is provided for all children in foster care with incarcerated parents at family-friendly settings within correctional facilities and supplemented by specialized supports • State has standards of minimal weekly visitation between children and parents.

Support for Kinship Caregiving

4 For children whose parents are unable to care for them even temporarily, the first priority is kinship care with relatives who are willing and able to provide safe, quality care. Compared to children in non-relative placements, children living with kin experience a range of positive outcomes:

- Higher scores on physical, cognitive, emotional and skill-based indicators,
- Fewer behavioral problems as rated by their teachers and caregivers,
- Increased placement stability and continuity,
- Safety levels that equal or surpass those of children living with non-relative foster parents,
- Greater satisfaction with the people they live with and fewer attempts to run away,
- Higher rate of placement with their siblings,
- Fewer school changes.[120]

Children who reunify with their birth parent(s) after kinship care are less likely to re-enter foster care than those who had been in non-relative foster placements or in group care facilities.[121] Care by willing and able kin is also a critical way to maintain lifelong connections with an extended kinship network.

Of the approximately 6 million children who live in households headed by a grandparent or other relative, 2.3 million do so without the presence of a parent in the household. Of these children, approximately 1.8 million were privately placed with kin without the involvement of the child welfare system. Of the 500,000 placed

with a relative following child welfare involvement, only about half are taken into state custody by the agency[122] – an arrangement often called "formal" kinship care or "kinship foster care." Many relative caregivers in both formal and informal kinship care arrangements are grandparents, and 20 percent live below the poverty line, often on fixed incomes.[123] Consequently, children in kinship care are more likely than children living with their parents to be raised in poverty and in a single caregiver household.[124]

Kinship foster care accounts for an estimated 30 percent of national out-of-home placements, with wide local variation. Increasing demand for foster care, shrinking numbers of non-kin foster care providers, changing attitudes regarding family care,[125] along with demonstrated benefits of family connections are driving the rise in kinship placements. Despite this growing reliance on kinship care, research demonstrates that children and caregivers in kinship foster care arrangements receive, request, and are offered fewer services and supports than non-kin foster caregivers.[126]

Kinship care is more common in communities of color. In Illinois, African American children are four to five times more likely to live in kinship care than white children. Support for permanency with kin can help reduce racial disproportionality in foster care, and adequate support for kinship caregivers can help improve outcomes for vulnerable children of color.

Congress and most state legislatures have codified the preference for placement with relatives. At the same time, a range of policies are key to making the connection with kin and providing the assistance that they, like other caregivers, need to nurture children who have experienced abuse or neglect. Policies supporting kinship caregivers that are described in other sections of this report include:

- Kinship navigators that help caregivers find and obtain assistance to support both the child's healthy development and their own capacity to parent. (See Policy I.5, Navigators to connect families with services.)
- Investment in parenting education and training, respite, and crisis care that help caregivers provide quality, stable homes for children if parenting challenges develop or as children's developmental needs change. (See Policy I..3, Parenting education and training and I..4, Respite and short-term crisis care.)
- Relative location and engagement strategies that help to identify kin as soon as a child comes to the attention of the child welfare agency and to ensure that appropriate kin are available to care for the child if removal is necessary. (See Policy 3.1, Location and engagement of kin.)

4.1 Permanent legal guardianship.

Permanent legal guardianship with kin is an important path to a permanent, stable home for children when neither reunification with their families nor adoption is possible or desired. Unlike adoption, guardianship does not involve termination of parental rights; therefore, it is an acceptable option for caregivers who oppose terminating parental rights on cultural, religious or personal grounds. In Native American tribes, where termination of parental rights is often considered abhorrent, legal guardianship is consistent with the traditional practice of customary adoption in which the tribe as a whole takes responsibility for child-rearing and individual members fill various roles within the child's life.[127] Legal Guardianship is also an option for caregivers who are willing to provide a permanent, loving home for a child, but are unwilling to disrupt family relationships or displace a family member with a disability or other problem that limits parenting. Many children and youth who understand the legal options for permanency and their implications prefer a permanent home with kin instead of adoption.

Guardianship has potential for reducing the number of children in foster care and especially the disproportional number of children of color. The Illinois Department of Children and Family Services implemented a range of strategies to reduce foster care, and it credits the state subsidized guardianship program established in 1997 as one of the cornerstones to its success. In 1997, 51,000 children were in foster care, 78 percent of whom were African-American. Now there are less than 16,000 children in foster care, 60 percent of whom are African-American. More than 10,000 children exited foster care to legal guardianship.[128]

When Congress enacted the Fostering Connections legislation in 2008, it gave states the option of using Title IV-E funds for kinship guardianship assistance payments for children raised by relatives in foster care. The child must have resided with the relative caregiver for at least six months, and must be eligible for Title IV-E foster care in order to receive the guardianship subsidy. Return home and adoption must also be ruled out in order to be eligible. Children eligible for federal guardianship assistance are also eligible for Medicaid. In addition, youth who leave foster care to guardianship (or adoption) after age 16 are eligible to receive independent living services and education and training vouchers.[129]

States can choose to opt into the federal guardianship assistance program in order to help children who can't return home or be adopted find a permanent home with relatives. States can consider the following components when developing subsidized guardianship programs and policies, include the following:

- **Set adequate subsidy levels.** Research demonstrates that children and youth are more likely to exit foster care to guardianship if subsidy levels are equal to what a child received while in foster care. In Maryland, the evaluation of their federal child welfare waiver demonstration for guardianship assistance found that inadequate benefit levels were a disincentive to permanency.[130] By contract, preliminary results from Minnesota's Permanency Demonstration Project find that setting foster care, adoption and guardianship subsidies at the same level can result in reduced lengths of stay and higher permanency rates.[131] (see policy area 5.1)
- **Provide guardianship for non IV-E eligible children.** States that opt into the federal IV-E guardianship assistance program can ensure that those children who are not IV-E eligible have access to guardianship through state funding. States that already had subsidized guardianship can use state or federal funding that was previously used to support children in guardianship before the federal program was authorized, or use savings from reduced foster care and court administrative costs to fund non IV-E eligible children.
- **Medical coverage.** Caregivers report that health care costs are a major deterrent to obtaining legal guardianship. Twenty-five states provided Medicaid or state health insurance coverage for children in legal guardianship arrangements before the federal program was enacted.[132] States can ensure that those children who are not eligible for Medicaid through the federal program have access to state health insurance coverage.
- **Age of eligible children.** In 2004, 11 states limited eligibility to children age 12 to 18. Because states have experienced the positive impact of legal guardianship for children and found legal guardianship to be appropriate for younger children, the trend is to expand eligibility to all ages.[133]
- **Access to child care assistance and other supports.** Many caregivers report that lack of affordable child care is another barrier to permanency. Eligibility for child care assistance is usually based on the guardian's household income and other requirements of the state child care assistance program. Expanding eligibility and otherwise increasing access to child care may increase the number of children who achieve permanency through legal guardianship. In New Jersey, for example, subsidies for day care or preschool are based in part on the caregiver's age, allowing a large number of guardians to access services.
- **Well-informed decisions by caregivers and children.** Connecticut and Idaho have amended their statutes to require dissemination of information about subsidized guardianship to all prospective guardians.[134] In Wisconsin, a subsidized guardianship agreement is required between the child welfare agency, the guardian, and, when appropriate, the child to ensure that all parties are fully informed about the rights, responsibilities and terms of the arrangement.[135]

- **Standby guardians.** To help ease the emotional and financial transition for the child if a guardian dies or becomes disabled, a few jurisdictions require or allow a prospective guardian to designate a co-guardian or standby guardian. Final transfer of permanent legal guardianship to the standby guardian is subject to court approval.

Policy Options: States can promote permanent legal guardianship by adopting and funding the implementation of 1, 2, 3, 4, 5, of 6 of the following policies:

- State provides subsidy levels that are equal to what a child would have received through foster care or adoption
- State provides guardianship subsidy and medical assistance for children who are not eligible for the federal guardianship assistance program.
- Permanent legal guardianship with kin is a permanency option that is actively explored for each child who cannot be reunified with his or her birth parents.
- Children of all ages are eligible for subsidized guardianship.
- Permanent guardians have expanded access to child care assistance.
- Permanent, legal guardians are encouraged to designate standby guardians.

4.2 "Preventive" permanent guardianship.

"Preventive" subsidized guardianship programs provide financial and other assistance to promote permanent homes for children with relatives before they enter foster care and are an emerging option that can help avoid the emotional trauma and disruption of foster care. In addition, preventing unnecessary placement in foster care decreases strain on already overwhelmed and under-financed child welfare systems.

Programs in six states (Kansas, Kentucky, Louisiana, New Jersey, Nevada, and Ohio) and the District of Columbia provide financial and other assistance to children living with kin who have become or are in process of becoming the child's permanent legal guardian. Although the monthly subsidy amount is greater than the level available through other basic financial assistance programs for low-income children or households (including the TANF child-only payments and state aid), it is lower than payments to licensed foster care providers and lower than adoption assistance. The exception is the District of Columbia subsidy, which is codified at the same level as guardianship assistance for children in the child welfare system.[136] In Ohio, instead of a monthly subsidy, the program provides incentive payments for legal guardianship that total up to $3,500 over three years in addition to TANF child-only assistance for qualifying children.

Often these subsidies are administered by the state or local agency that administers TANF and other state financial assistance to families; therefore interagency referrals and coordination are critical to ensure that caregivers who may be able and willing to provide permanent homes have access to the resources (See Policy Area 14.1, Interagency Collaboration: Funding flexibility).

Along with a subsidy, programs can be designed to provide additional assistance:

- **Financial assistance for legal services or initial costs of assuming care.** In addition to a monthly subsidy, the Kentucky, Nevada, and New Jersey programs offer financial assistance for the legal costs to obtain guardianship and/or funding for approved one-time expenses associated with assuming care (such as furniture or rental deposit for larger housing). In New Jersey, legal assistance is also extended to help the guardian adopt the child.
- **Medical coverage.** Most programs ensure access to health care for participating children by defining subsidy eligibility to comply with the state's Medicaid plan.
- **Child care assistance.** All participants in Ohio's Kinship Permanency Incentive Program are eligible for the state's Early Learning Initiative.
- **Other supports.** Based on the needs of individual children and their caregivers, other supports may include respite care, transportation, and case management (Kansas and Nevada); wraparound funds and navigator services (New Jersey); and child and grandparent counseling, parenting skills training, and childhood immunizations and other screening (Kansas).

Policy Options: States can promote "preventive" permanent guardianship by adopting and funding implementation of 1, 2, 3, 4, 5, or 6 of the following policies:

- Financial subsidy is provided to prevent foster care by assisting kin willing and able to obtain permanent legal guardianship.
- Financial assistance is available for legal costs to obtain guardianship and/or to adopt.
- Financial assistance is available for one-time expenses.
- Eligibility for health care coverage for the child is provided.
- Eligibility for child care assistance is provided.
- Other supports are available based on the child and caregiver's needs.

4.3 Eliminating financial disincentives for kinship care.

To ensure adequacy and parity of financial support for kinship caregivers, payments should be equal to standards recently established for the basic care of children in foster care. More than 54 percent of children in kinship care live in families with

incomes below 200 percent of the poverty line. Many times, a relative's reasons for not taking in a child are strictly financial. In other families, caregivers struggle financially to provide adequate care for the child. Financial assistance that helps children participate in the benefits of relative care includes:

- Assistance for children in kinship care who are not in state custody, including state-only funds and TANF child-only grants,
- Foster care payments,
- Subsidies for children in the custody of permanent legal guardians (see Policy Area 4.1),
- Adoption assistance.

Incentives to permanency and family connections are promoted by ensuring parity of payment levels and duration of all forms of assistance to children in kinship care arrangements. As of 2004, 11 states required that monthly subsidy levels for children living in permanent guardianship must equal foster care payments. In New Mexico and North Carolina, the payment must equal the higher adoption assistance payment.[137] However, in addition to parity, payment levels must be adequate to recruit kinship caregivers, to promote stable placements with kin, and to provide safe and quality care to children.

Recently Children's Rights, the National Foster Parent Association and the University of Maryland School of Social Work established a basic foster care payment rate for each of the 50 states that is based on an analysis of the real costs of providing care.[138] Payments to caregivers should equal these levels.

Policy Options: States can eliminate financial disincentives for kinship care by requiring that financial assistance for the care of children in all types of kinship care arrangements meets or exceeds standards established for minimum, adequate foster care or adoption assistance rates.

4.4 Medical consent and school enrollment.

Many kinship caregivers who do not have legal custody encounter barriers to obtaining medical treatment and educational services for the children they are raising. Because the child's parents retain legal custody, the relative is unable to provide consent for the child's medical and mental health treatment or to enroll the child in school or extra-curricular activities.

Half the states and the District of Columbia have enacted legislation that authorizes grandparents and other relative caregivers to access medical care and treatment for children, and 21 states allow caregivers to enroll children in schools. These laws

carry certain conditions. They generally cover a limited time period, allow parents to rescind their consent at any time, require caregiver affidavit forms, offer immunity for providers, and provide penalties for false statements.[139]

Policy Options: States can remove barriers for children and their kinship caregivers by adopting either or both of the following policies:

- Kinship caregivers can obtain legal authority to access medical care and treatment for children.
- Kinship caregivers can obtain legal authority to enroll children in school and extra-curricular activities.
- Kinship caregivers can access financial assistance in choosing medical and educational options.

Policy Area 4: Support for Kinship Caregiving Summary of Policy Options

Policy Area	Policy Options
4.1 Permanent legal guardianship	Promote permanent legal guardianship by adopting and funding the implementation of 1, 2, 3, 4, 5, of 6 of the following policies: • State provides subsidy levels that are equal to what a child would have received through foster care or adoption • State provides guardianship subsidy and medical assistance for children who are not eligible for the federal guardianship assistance program. • Permanent legal guardianship with kin is a permanency option that is actively explored for each child who cannot be reunified with his or her birth parents. • Children of all ages are eligible for subsidized guardianship. • Permanent guardians have expanded access to child care assistance. • Permanent, legal guardians are encouraged to designate standby guardians.
4.2 Preventive permanent guardianship	Promote "preventive" permanent guardianship by adopting and funding implementation of 1, 2, 3, 4, 5, or 6 of the following policies: • Financial subsidy is provided to prevent foster care by assisting kin willing and able to obtain permanent legal guardianship. • Financial assistance is available for legal costs to obtain guardianship and/or to adopt. • Financial assistance is available for one-time expenses. • Eligibility for health care coverage for the child is provided. • Eligibility for child care assistance is provided. • Other supports are available based on the child and caregiver's needs.
4.3 Eliminating financial disincentives for kinship care	Eliminate financial disincentives for kinship care by requiring that financial assistance for the care of children in all types of kinship care arrangements meets or exceeds standards established for minimum, adequate foster care or adoption assistance rates. • Medical consent and school enrollment • Remove barriers for children and their kinship caregivers by adopting either or both of the following policies: • Kinship caregivers can obtain legal authority to access medical care and treatment for children. • Kinship caregivers can obtain legal authority to enroll children in school and extra-curricular activities. • Kinship caregivers can access financial assistance in choosing medical and educational options

Adoption

5 When children in foster care can not return home, adoption is the best possible option for long term security with a family. Adoption from foster care can provide children with the safety and security of a permanent family. It also helps to prevent the negative outcomes associated with aging out of foster care with no permanent home. (see Policy area 7, "Youth in Transition to Adulthood" which summarizes this research)

Adoption not only benefits the individual child, but has long term social and financial benefits to society. Research has shown that both the public and private benefits of adoption are considerable. In terms of public benefits, adoption helps to prevent the long term costs of foster care, special education and juvenile justice involvement. Private benefits include the income contributed to society over the life of an adopted child. The research concludes that a dollar spent on adoption subsidy yields approximately three dollars in benefits to society.[140]

Another study estimates that for the 50,000 children adopted from foster care each year, government savings range from $3.3 billion to $6.3 billion, depending upon the subsidy rate provided in the state.[141] Savings are realized by the reduced foster care costs associated with children exiting foster care, as well as the negative outcomes and costs associated with children aging out of care.

Adoption from foster care has received considerable attention, particularly since enactment of the Adoption and Safe Families Act of 1998. This act provided

additional support to children awaiting adoption by tightening the timeframes for making decisions about children in foster care and requiring more oversight of case plans by child welfare agencies and the courts. It also provided incentives to states to achieve adoption for children with special needs, including older children and children of color. As a result adoptions have more than doubled over the last decade. In 1995, there were 25,000 adoptions from foster care. Today, public agencies consistently find adoptive families for 50,000 children in foster care who can not return home.[142]

Despite these successes, there is still much work to be done. In 2006, there were 130,000 children waiting to be adopted. Of these waiting children, 84,000 already had their parental rights terminated and were legally free for adoption. Many of these children have been in foster care too long. Of the 130,000 children waiting to be adopted from foster care in 2006, 60% had been in foster care two years or more.[143]

Policymakers have a range of policy options available to them to further enhance the adoption of children from foster care. These include policies designed to strengthen the subsidy and benefits program for children adopted from foster care, as well as those intended to streamline court processes for oversight and termination of parental rights. Policies that can further promote adoption from foster care include the following options.

5.1 Adequate adoption subsidies and benefits.

Research has shown that increases in adoption subsidies can result in more children who are adopted from foster care.[144] Providing adoptive families with adequate resources to care for children who have been abused and neglected also enhances the likelihood that the adoption will be successful.

Given the substantial increase in adoption from foster care over the past decade, some policymakers might be tempted to cut adoption subsidies as a way to deal with budget shortfalls. Yet these cuts have longer term costs down the line: costs in public benefits to support youth in long term foster care, the cost of bad outcomes for youth who age out of care, and public and private costs associated with lower earnings and unproductive lives.

Adequate adoption subsidies are particularly important given that at least 60% of the children adopted from foster care are adopted by their foster parents. While some states provide adoptive families with the same benefits they received while the child was in foster care, others may reduce the subsidy at the time of adoption, making it difficult for families to meet the child's on-going needs.

Minnesota is providing continuous benefits for foster care, adoption, and legal guardianship through its Permanency Demonstration Project. Funded through a waiver from the federal government, the project equalizes subsidy rates so that families do not have to take cuts in benefits for children they had in their home as foster children and have an incentive to adopt or take legal guardianship. Interim findings halfway into the project (2.5 years) suggest that children in families offered the single benefit have higher rates of permanency and spend less time in foster care than those who are offered subsidy levels under the traditional programs offered by the state.[145] In Virginia, the 2008/9 biennial budget included a 23% increase in foster care and adoption subsidies. The increase responded to studies that showed the inadequacy of the existing subsidies.[146]

In addition to subsidies, many adoptive children need access to educational benefits that might be beyond the reach of their adoptive families. Educational benefits are provided to many youth in foster care. As a result, some youth are reluctant to agree to adoption because they will lose the benefit, creating a disincentive to permanency. Connecticut legislation enacted in 2005 allows adopted youth to receive tuition assistance similar to what youth in or aging out of foster care receive.[147] The Fostering Connections legislation makes children who leave foster care after age 16 eligible for independent living services and education and training vouchers.

State tax credits can also supplement the federal tax credit as a way to provide further incentive for adoption from foster care. The federal credit — equal to $11,650 in 2008 — is available for adoption of a child with special needs. Most children adopted from foster care qualify for the tax credit and federal statute requires states to inform all people who adopt or are known to be considering adopting a child from foster care that they are potentially eligible for the adoption tax credit. The tax credit can be claimed in the year in which the adoption is finalized and can be used for up to five years after the adoption finalization.[148] Rhode Island statute allows families who are eligible for the federal tax credit to claim a credit against state income taxes as well.[149]

Policy Options: States can promote lasting adoption from foster care by supporting adequate adoption subsidies and other benefits that the child would have received in foster care by adopting one or more of the following policies:

- Adoption subsidies that are at least equal to what a child received in foster care
- Subsidies and benefits that are adequate to meet the needs of the child
- Benefits, including educational benefits, that are available to youth who age out of foster care
- State tax credits

5.2 Streamlined court processes.

Court delays can have a significant impact on a child's ability to get adopted when return home is not possible. Many actions can be taken to improve court performance and strengthen court and child welfare relationships. For more information on these, see Policy area 12.

In the area of adoption, court related days can create significant barriers. In a 2004 survey of state child welfare agencies, several states highlighted court related barriers to foster care adoption, including:

- 48 states reported significant barriers to conducting TPR proceedings
- 43 states reported barriers in court case management, including continuances, crowded dockets, difficulty scheduling hearings and lack of communication
- 30 states reported barriers around conducting proceedings when a child's birth parents appeal the termination of parental rights[150]

Policymakers can hold courts and child welfare agencies accountable for ensuring that families have timely and substantive court hearings, and that court delays do not stand in the way of achieving adoption goals.

New York's Permanency Legislation requires a permanency hearing to be held within 8 months of a child's placement in foster care (rather than 12 months) and every six months thereafter. It also specifies the contents of the permanency hearing reports to the court and requires the child welfare agency to provide the reports to the court and all attorneys at least 14 days before the hearing. The permanency legislation also provides for continuous court jurisdiction from child protection through foster care and adoption so that a child's case is not heard in different courts. The permanency legislation contains many other procedural changes aimed at reducing bureaucratic delays within the courts.[151]

Georgia and Tennessee laws have been enacted to tighten the timeframe for completing termination of parental rights. Georgia law requires hearings to terminate parental rights to be held 90 days from when the petition is filed.[152] Tennessee statute requires that the TPR hearing be held within 6 months of the petition.[153]

Policy Options. States can help to reduce court barriers to adoption by adopting policies that streamline court processes, including:

- Require more frequent court hearings to establish permanency goals
- Tighten timeframes for termination of parental rights
- Ensure appeals processes do not unduly delay adoptions
- Provides for continuous court jurisdiction for children through the adoption process

5.3 Post adoption services.

Many adoptive families report the need for on-going help even after the adoption has been finalized. Post adoption services and supports can respond to the unique challenges of special needs children, many of whom continue to have emotional, behavioral or physical challenges that need to be addressed. While adoption provides them with the comfort and safety of a permanent and loving family, these families will continue to need support to stay together.

According to a 2002 assessment of the post adoption needs of adoptive families, on-going support is needed in five areas: information (lectures, seminars, training and workshops); clinical (counseling and mental health services); respite, material services, and support networks.[154] Some of the services that work to keep families together are the same that are outlined in Policy Area 2: Preserving and Reunifying Families, particularly Intensive Home Based Services. Others are unique to families with children with special needs, including adoption competent mental health services and support groups for adoptive families.

Many agencies use Title IV-B funding, the Promoting Safe and Stable Families Program, to support post adoption services. Under the terms of the PSSF, states are allowed to use Title IV-B, Subpart 2 funds for adoption support and preservation. Oregon uses PSSF funding for the Oregon Post Adoption Resource Center (ORParc), which provides post adoption resource statewide. Other states, such as Illinois, have dedicated units within the public agency to provide access to services for adoptive families.

Policy Options: States can support adoptive families to stay together by promoting any of the following options:

- Require state agencies to provide access to post adoption services for families who adopt children from foster care
- Fund post adoption services with state dollars, or funding saved from reducing the number of children in foster care
- Require state agencies and/or courts to assess family needs for post adoption services during the annual subsidy re-determination process
- Require that evidence based practices supported by local, state or federal funds be assessed for their relevance to the post adoption needs of families

Policy Area 5: Adoption Summary of Policy Options

Policy Area	Policy Options
5.1 Adequate adoptions subsidies and benefits	Promote lasting adoption from foster care by supporting adequate adoption subsidies and other benefits that the child would have received in foster care by adopting one or more of the following policies: • Adoption subsidies that are at least equal to what a child received in foster care • Subsidies and benefits that are adequate to meet the needs of the child • Benefits, including educational benefits, that are available to youth who age out of foster care • State tax credits
5.2 Streamlined court processes	Help to reduce court barriers to adoption by adopting policies that streamline court processes, including: • Require more frequent court hearings to establish permanency goals • Tighten timeframes for termination of parental rights • Ensure appeals processes do not unduly delay adoptions • Provides for continuous court jurisdiction for children through the adoption process
5.3 Post-adoption services	Support adoptive families to stay together by promoting any of the following options: • Require state agencies to provide access to post adoption services for families who adopt children from foster care • Fund post adoption services with state dollars, or funding saved from reducing the number of children in foster care • Require state agencies and/or courts to assess family needs for post adoption services during the annual subsidy re-determination process • Require that evidence based practices supported by local, state or federal funds be assessed for their relevance to the post adoption

Family Foster Care Resources and Support

6

For children who cannot remain with their own parents and cannot be placed with kin, the best option for temporary care until permanency can be achieved is family foster care. The most effective foster care preserves the child's connections with family and community and is provided by a foster family who has adequate training, supports, and other resources to meet the child's needs. Although outcomes are best for children in the least restrictive, most family-like, and stable setting possible, foster care is intended as a temporary placement until the child can be safely reunified with his/her family, achieve a permanent home with caring and capable kin, or be adopted.

Starting in the 1980s, overuse of congregate care — which includes emergency or shelter care, group care, residential care, and psychiatric or hospital settings — became common, as the number of children in foster care began increasing dramatically. At the same time, children entering care have demonstrated more severe health and behavioral problems and availability of family foster care providers has decreased. Workers' growing caseloads hinder the necessary monitoring of placements and development of alternatives to move children out of group care. As a result, children and youth have lingered not only in foster care but in overly restrictive congregate care facilities. In addition, the longer children and youth stay in congregate care, the less likely they are to make a successful transition back into their families, communities, or mainstream society.

Research indicates that congregate care should be the placement of last resort and that when it cannot be avoided, it should be as brief as possible. A rigorous study by

U.S. researchers in Romania shows that stays in orphanages affect the brain development of young children. Toddlers placed in quality foster homes scored dramatically higher on IQ tests years later than children who stayed in orphanages, and those with the longest stays suffered the most severe impacts.[155] Other studies show that children and youth who spend the majority of their placement time in highly restrictive settings complete fewer years of school, have poorer school achievement, and lower educational aspirations than children in less restrictive settings.[156] Even when congregate care is reserved for children and youth who display seriously violent and aggressive behavior, these behaviors do not appear to improve in such settings.[157]

Congregate care is also a costly intervention — with the average monthly cost of residential treatment from $5,000 to $6,000 per month.[158] These funds can be better invested in preventing child abuse and neglect, providing supports for families to reduce the need for out-of-home placement, and supporting kin and family foster care providers when placement is unavoidable.

Like other child welfare goals, reducing congregate care and shifting placement to kin and family foster care requires a combination of policy strategies, rather than a single response. Strategies that support family foster care include family supports described in Policy Area I of this report — parenting education and training, respite and short-term crisis care, and navigators.

6.1 Family foster care within the child's own geographic and cultural community.

Family foster care placements in geographically and culturally familiar settings may improve placement stability and other positive outcomes. An Illinois study found that children placed outside their own neighborhoods were 55 percent more likely to experience subsequent instability than those placed near their homes of origin.[159] Illinois children in state custody, the vast majority of whom are African American, experienced 75 percent more moves within a year if placed in white families than if placed with African American families.[160]

Recommended policies are based on community and agency experiences as well as the opinions of national and local experts, who believe that placement within the child's home community can help reduce the trauma of separation and increase the possibility, timeliness, and quality of family reunification.[161] The Annie E. Casey Foundation's Family to Family Initiative promotes local collaboratives that serve children in neighborhood foster homes so the relationships between the children, their primary families, and their natural support networks can be maintained.

The Family to Family Initiative identifies neighborhoods with high child protection referral rates and then recruits, develops and supports kin and foster families who can care for children within their own neighborhoods. Denver County, Colorado, for example, is investing in seven community collaboratives that recruit local foster families, support kinship placements, advocate for needed services in the communities in which families live, and more.[162]

In 2002, 26 child welfare agencies from across the country, representing more than 94,000 children in out-of-home placement, participated in a Breakthrough Series Collaborative (BSC) sponsored by Casey Family Programs on strategies for recruiting and retaining foster and adoptive resource families. The BSC is a method that originated in the health care field for rapidly testing small-scale changes, often making multiple cycles of modifications, and, when deemed successful, quickly spreading the changes throughout the system. Participating agencies identified key themes of effective strategies: culturally sensitive recruitment of foster families, creating partnerships with the faith community in recruitment, and learning about, educating, and engaging targeted communities in recruitment efforts.

Policy Options: States can promote placement in a child's community by adopting either or both of the following policies:

- Foster family recruitment is targeted to neighborhoods with high placement rates and to communities of color (whose children are disproportionally represented in the foster care population).
- Placements that maintain a child's ties to his/her geographic and cultural community are required.

6.2 Investment in supports for foster families.

A host of factors contribute to low foster family recruitment and retention rates, and a combination of strategies is necessary to reduce turnover and improve the quality of family foster care. Turnover among foster parents is estimated at 30 to 50 percent per year in some places.[163] Among the reasons foster parents cite are lack of agency and caseworker support, poor communication and treatment from child protection workers, difficulty with a child's behavior, inadequate services for the children in their care, poor training, and caseworker turnover.[164] Illinois caseworkers attribute more than a quarter of all moves that children experience to the unwillingness or inability of foster caregivers to tolerate children's emotional or behavioral problems.[165]

While evidence regarding the effectiveness of many strategies is still underdeveloped, states are implementing a number of promising efforts to improve retention and recruitment of foster parents. For example, at least seven states provide respite care

to either all foster parents or those caring for children with special needs (See Policy Area 1.4; Support for families, Respite and short-term crisis care). Connecticut and Oregon are among states that extend public health insurance programs to foster parents and their dependents. Iowa helps finance and support the Foster and Adoptive Parent Association, which assists in recruitment, support, and training its members. At least ten states offer some form of reduced liability or liability protection to foster parents, and a number of states offer training and peer support.[166]

Policy Options: States can authorize and fund 1, 2, or 3 of the following supports and incentives for foster families:

- respite services for foster parents
- health insurance coverage for foster parents and their dependents
- reduced liability or liability protection

6.3 Adequate financial support for family foster care.

An adequate level of financial support for foster care providers contributes to recruitment and retention of foster families, may limit the number of children's placement moves, and helps to ensure that the basic needs of children in family foster care are met. Foster parents and other advocates routinely report that current payment rates in most every state do not cover actual costs, and there is some evidence that inadequate rates negatively affect foster parent recruitment and retention and the care that children in foster care receive. Research documents that foster parents incur expenses that exceed foster care rates, often pay out of their own pockets to meet children's needs, and consider no longer providing care as a result of financial strain.[167]

A recent study established "Minimum Adequate Rates for Children in Foster Care" (MARC) for each of the 50 states and the District of Columbia by analyzing consumer expenditure data reflecting the costs of caring for a child, identifying and accounting for additional costs particular to children in foster care, and applying a geographic cost-of-living adjustment. These calculations are based on expenditures that are allowable under the Title IV-E Foster Care Maintenance Program, which defines foster care maintenance payments as covering the cost of providing food, clothing, shelter, daily supervision, school supplies, personal incidentals, insurance and travel for visitation with a child's biological family.[168]

Policy Option: States can authorize and fund foster care payment rates that meet M.A.R.C. standards.

6.4 Prohibition of congregate care for young children.

A growing body of research provides strong evidence that young children should not be placed in congregate care settings unless they have serious medical needs that cannot be met in another setting. Stringent, scientific evidence that institutional care diminishes the brain development of young children includes a longitudinal study of young children in Romanian orphanages and quality family foster care. By age 4 1/2, children in foster care were scoring almost ten points higher on IQ tests than children who remained in orphanages. Children who left the orphanages before age two saw an almost 15-point increase.[169] Another study comparing the experiences of children in foster care and those in group homes shows that children in group home settings score lower on developmental and psychomotor assessments than those in foster homes.[170]

Nevada legislation will go into effect in 2008 that prohibits placement of a child under age three in congregate care unless it avoids separating siblings or the child requires medical services that cannot be provided in another setting. In 2009, the prohibitions and requirements will be extended to children under age six. (Nev. Rev. Stats., 432B.3905)

In Arizona, state agency policy prohibits placement of children under age two in congregate care settings, including emergency shelters, unless a specific procedure certifies that the placement is unavoidable. Numerical goals for reducing the number of children by different age categories and lengths of stay were critical to holding the Department accountable for reducing reliance on shelter care.[171] In Denver County, Colorado, emergency shelters stopped accepting children under age 12 in 2003.[172]

Policy Options: States can prohibit placement in congregate care (unless the child's documented medical needs cannot be met in a less restrictive setting) for children in the following age categories (listed in increasing order of the number of children affected):

- Under 3 years of age
- Under 6 years of age
- Under 12 years of age

6.5 Alternatives to reduce the need for congregate care.

Reducing reliance on congregate care requires development of a continuum of enhanced forms of family foster care. Jurisdictions including New York City and select counties in California and Washington have achieved significant success moving children out of congregate care directly into the homes of caring kin or foster families. In 2003, the New York City Administration for Children's Services (ACS) began implementation of its Congregate Care Reduction Initiative, designed to end the City's over-reliance on group and residential care as placement resources for older children and youth. Family-based placements were developed, and more than 48 facilities were closed, eliminating 535 congregate care beds.[173]

Evidence-based outpatient treatment. For some children, family foster care together with outpatient treatment for medical, mental health and other disabilities allows movement out of congregate care. In Denver, multi-systemic therapy has helped reduce the length of stay in congregate care for some young people (See Policy Area 2.6 Home and community-based services for families and children with mental illness: Children with Mental Health Problems, Evidence-based, home and community mental health services).

Therapeutic foster care. Highly trained foster families who provide intensive supervision and case management and receive higher payments are effective alternatives for children with emotional, behavioral and mental health problems. In addition to the child's basic needs for shelter and care, therapeutic foster care includes services and treatment tailored to meet the child's unique needs.[174]

Evidence-based models of enhanced foster care. Program evaluations support specific models of enhanced family foster care that provide comprehensive supports for both children and foster care providers.

The Mockingbird Family Model (MFM) places foster youth in the center of a community of four to ten foster or kinship homes in a given neighborhood. At the center of the constellation is a Hub Home operated by licensed foster parents who coordinate special events, youth activities and emotional resources to support foster youth and other parents in the cluster.[175] The model includes respite, placement of siblings together, cultural/ethnic consideration (for example, foster parents with the same background), respite care, crisis respite, and family social activities. Initial, small scale evaluation results are positive, and participating foster families are enthusiastic. Eighty-four percent of children remained in one foster home consistently over the period evaluated. According to foster parents, placement disruptions were prevented by the availability of MFM respite and support.[176]

In the Neighbor to Family Program, foster caregivers strive to enable siblings in foster care to live together close to home in their own communities, while efforts are made to reunite them with their families. Caregivers are trained and salaried staff members who act as mentors with biological parents and receive 24-hour support and benefits. They are part of specialized multidisciplinary teams that offer case management, therapeutic and counseling services, permanency planning and other related services. Between 1998 and 2002, Neighbor to Family served 42 sibling groups with 143 children, with high rates of joint sibling placement and placement stability. Programs are located Daytona Beach, Fort Lauderdale, Orlando and Gainesville, Florida; as well as Baltimore, Maryland; Norfolk, Virginia; and 4 counties in Georgia.[177]

Policy Options: States can reduce reliance on congregate care by authorizing and funding 1, 2, or 3 of the following placement alternatives:

- Evidence-based out-patient treatment
- Evidence-based therapeutic foster care
- Evidence-based models of enhanced family foster care.

Policy Area 6: Family Foster Care Resources and Support Summary of Policy Options

Policy Area	Policy Options
6.1 Family foster care within the child's own geographic and cultural community	Promote placement in a child's community by adopting either or both of the following policies: • Foster family recruitment is targeted to neighborhoods with high placement rates and to communities of color (whose children are disproportionally represented in the foster care population). • Placements that maintain a child's ties to his/her geographic and cultural community are required.
6.2 Investment in supports for foster families	Authorize and fund 1, 2, or 3 of the following supports and incentives for foster families: • Respite services for foster parents • Health insurance coverage for foster parents and their dependents • Reduced liability or liability protection
6.3 Adequate financial support for family foster care	Authorize and fund foster care payment rates that meet M.A.R.C. standards.
6.4 Prohibition of congregate care for young children	Prohibit placement in congregate care (unless the child's documented medical needs cannot be met in a less restrictive setting) for children in the following age categories (listed in increasing order of the number of children affected): • Under 3 years of age • Under 6 years of age
6.5 Alternatives to reduce the need for congregate care	Reduce reliance on congregate care by authorizing and funding 1, 2, or 3 of the following placement alternatives: • Evidence-based out-patient treatment • Evidence-based therapeutic foster care • Evidence-based models of enhanced family foster care.

Well-being of Children Who Experience Out-of-Home Placement

7

Child well-being is a complex achievement that requires adequate nutrition, health care, and shelter; multiple supportive relationships with adults and peers; challenging and engaging activities and learning experiences; meaningful opportunities for involvement and membership; and physical and emotional safety.[178] For children who are involved with the child welfare system and especially those in foster care, well-being is a hard-won goal. Compared to their peers, they face much greater risks and poorer outcomes, including higher rates of physical disabilities and developmental delays, poor academic engagement and performance, serious emotional and behavioral problems, and fewer social skills. About 60 percent of children in foster care have a chronic medical condition, while 25 percent have three or more chronic problems. Fifty to 80 percent of children in foster care have moderate to severe mental health and behavioral problems, and up to 60 percent have at least one psychiatric disorder. About 60 percent of preschool age children in foster care have developmental delay.[179]

By definition, children involved with the child welfare system are likely to have experienced trauma. The majority have experienced neglect, which may be associated with poor prenatal care, malnutrition, under-treated illnesses, immunization delays, the effects of parental depression or stress, and lack of access to needed social and educational services. At least one-third of children in the child welfare system are victims of sexual, psychological or physical abuse, often at the hands of a parent or

caregiver, and for these children the emotional wounds can be severe and the impact devastating.[180] The majority of children in foster care are under age five, and for them the impact of trauma on healthy development is especially acute.[181]

In addition to the negative effects of the experiences that brought them into the child welfare system, these vulnerable children often experience further harm caused by separation from family, frequent placement moves, inappropriate placements, and lack of access to needed services and supports. Because multiple factors can negatively impact a child's development, it is essential that all children in foster care have access to comprehensive assessment, ongoing monitoring, and an array of services to meet their needs. Policies to help ensure effective assessment, monitoring, and individualized case planning for children involved with the child welfare system are addressed in another section of this report. (See Policy 9.1, Individualized and comprehensive assessments and planning.) This section suggests policies that can improve access to services that research documents improve child well-being.

7.1 Access to quality early care and education.

Young children in foster care stand to gain a range of benefits from participation in high quality early care and education. Brain research shows that the foundations are laid in infancy and early childhood for trust, self-esteem, conscience, empathy, problem solving, focused learning, and impulse control.[182] Early childhood is an especially critical time for the neurological and cognitive development of children in foster care. As many as 59 percent of foster children aged two months to two years are at high risk for a clinical level of impairment.[183]

Extensive research over many years has demonstrated that high quality early care and education programs have a positive impact on virtually all measures of child development, including cognitive skills, school achievement, social skills, and reduced conduct problems.[184] In addition, child care centers, head start facilities, and preschools are emerging as strategic and feasible venues for building protective factors critical to child abuse and neglect prevention and to effective responses to families in time of crisis.[185] Programs that have a positive impact incorporate specific, high quality components, including family support services, parental classroom involvement, and home visits from a school representative.[186]

To benefit from high quality programs, children in foster care must be ensured access to the programs. However, studies show that young children involved with the child welfare system are less likely than other children to have access to developmental services.[187] Only 18 percent of the foster parents in a 2000 New York study reported

that children in their care were enrolled in preschool programs; most said that no one advised them to enroll the children.[188]

With the 2003 Rilya Wilson Act (2003 Fla. Laws, SB 1318, Chap. 292), the Florida Legislature stated its intent that children in state care receive an age appropriate education to help ameliorate the negative effects of abuse, neglect and abandonment. The Act requires that case plans specify participation in child care and, for those participating in early education programs, enrollment five days per week.[189]

California legislation provides a mechanism to finance child care for children in foster care. It requires the state child welfare agency to allow counties to use federal Title IV-E funds to subsidize child care by amending the state foster care plan. (2004 Cal. Stats., SB 1612, Chap. 845)[190]

Policy Options: States can promote participation in quality early care and education among young children in foster care by adopting and funding the implementation of one of the following policies:

- Participation is mandatory up to school age
- Participation is mandatory for children ages three to five
- Participation is available for children from birth to age three

7.2 Educational advocates or liaisons.

Educational outcomes for children in foster care may be improved if they have trained and informed adults serving as their advocates with the school system, or if there are liaison staff responsible for improving child welfare-education coordination and performance. Compared to their peers, children in foster care experience higher dropout rates as well as higher rates of grade retention, truancy, absenteeism and tardiness. Responsibility and accountability for the educational outcomes of children in foster care are often unclear, and the children often lack a consistent, knowledgeable adult who can advocate on their behalf for appropriate and effective educational services.[191] Youth, caregivers, and child welfare agencies identify lack of educational advocacy as one of the child welfare system's major shortfalls and, when available, as one of its most important assets.[192] In addition, lack of adequate educational advocacy was cited as a problem by the federal Child and Family Services Reviews (CFSRs) for 14 of the first 37 states reviewed.[193]

A study of 25 children in foster care and the key adults in their lives found that the children were missing the adult understanding, involvement and advocacy in their education that children who succeed in school experience. Foster parents were most

concerned with the children's behavior; and they rarely expressed concern with their foster children's poor grades or helped with homework. Caseworkers generally were unaware of children's school performance. School staff seldom had information of a child's background or foster care experiences, rarely understood how those factors might affect educational achievement, and were unaware when the demands of the foster care system (such as medical appointments, therapy, or court appearances) caused children to miss tests or other assignments. In addition to educational advocacy for children in foster care, researchers and experts recommend improved communication and coordination among child welfare and school representatives and basic training for teachers and other school personnel on the overall structure and function of the child welfare system.[194]

The Individuals with Disabilities Education Act (IDEA) provides for the appointment of a surrogate to advocate and make decisions on behalf of a child regarding special educational services, if the child is a ward of the state. Some state laws require that relative caregivers, foster parents or court-appointed special advocates be given first preference for appointment as a surrogate.[195] New Hampshire legislation, for example, authorizes foster parents to act as educational advocates.

Another approach is use of educational liaison staff or consultants to enhance interagency coordination on behalf of children in foster care. The Connecticut Department of Children and Families (the State child welfare agency) contracts with six educational consultants, each of whom covers a different region of the state and is a former teacher, administrator, or school psychologist. Their duties include consulting with caseworkers on children's educational needs, advocating with schools for appropriate services, reviewing children's educational records, conducting educational testing and evaluation, observing children and consulting with foster parents, participating in special education planning, and acting as liaison between the child welfare agency and the education system.[196]

California Assembly Bill 490 passed in 2003, requires each local educational agency to designate a staff person as the educational liaison for children in foster care. In Contra Costa County, California, educational liaisons are employees of the county Office of Education but are placed in the child welfare agency.

Policy Options: States can promote the availability of trained and informed educational advocates or liaisons by adopting 1, 2, or 3, of the following policies:

- Kinship caregivers, foster parents or court-appointed special advocates have preference for appointment by the court as educational surrogate or advocate.
- Educational advocates must be available within the child welfare system
- Educational advocates must be available within the school system

7.3 Medical coverage.

Many children in foster care do not receive adequate health care services. In a 2005 analysis of state child welfare performance, the U.S. Department of Health and Human Services (HHS) found that only one state met federal standards for health and mental health services delivery to children involved with the child welfare system. In more than 30 percent of the cases reviewed, child welfare agencies failed to provide adequate services,[197] despite a mandated responsibility for meeting the health and mental health needs of children in their custody. In 2008, Congress included a provision in the Fostering Connections legislation that requires states to work with Medicaid agencies to develop a plan for oversight and coordination of health care services for children in foster care. The plan must include specific steps that will be taken to assess, treat and monitor the comprehensive health care needs of foster children.[198]

Medical coverage for children in foster care can be achieved through a mix of funding strategies that involve federal and state sources (See Policy Area 14.1 Interagency collaboration: Funding flexibility). The interplay between Title IV-E and Medicaid is the first and most critical step in providing comprehensive medical coverage. Foster children who are eligible for Title IV-E foster care reimbursement are also Medicaid-eligible and all states also extend Medicaid eligibility to children in foster care who are not IV-E eligible. At the same time, each state develops and administers its own Medicaid plan — determining eligibility standards, services, and payment rates in compliance with federal rules. Relying upon existing Medicaid plans for foster children introduces the inherent challenges that can undermine the effectiveness of Medicaid services. These challenges include lack of mental health services for children, an insufficient number of doctors and dentists willing to accept Medicaid, inconsistency in conducting adequate and timely health and mental health assessments, and inconsistent provision of preventive health and dental services.[199] In 2002, the federal government designated 3,216 geographic areas as "shortage areas" for primary care health providers; 1,953 are so designated for dental health providers; and 963 are designated as having mental health provider shortages.[200] Strategies for making health care available to under-served children and families are outlined in the Policy Matters publication, *Promoting Better Family Health: Recommendations for State Policy.*

Funding Strategies: Because states have great leeway in determining their Medicaid programs, there is enormous variation in spending per child in foster care. For example, a 2005 Urban Institute analysis found that Medicaid spending per foster child ranged from $1,309 in Arizona to $19,408 in Maine. The average expenditure per enrollee for all children in foster care is $4,336. Twelve states expended more than $8,000, while 11 states spent less than $3,000 per enrolled foster child.[201]

States can begin to address these variations through an examination of Medicaid options and waivers.

Coordinating the funding streams to fund comprehensive health care for children in custody requires a cross-agency analysis of allowable uses and limitations. Many states have formed task forces to develop health care plans that include an evaluation of all potential funding sources, allowable uses, waivers and options.[202] Funding strategies that emerge blend funds that cover administrative costs versus clinical services, include state funds for non-reimbursable costs, and include funding from different agencies. Finally, incentives for providers should be explored (See Policy Area 10.3: Monitoring and Oversight Systems, Performance Based Contracting) to encourage the development and provision of special services.

Targeted case management. Case management that can help an eligible individual gain access to needed services can be covered when a state is permitted a Medicaid-approved targeted case management (TCM) option. Thirty-eight states have designated children in foster care as a targeted population for case management services. TCM recipients are more likely than non-TCM recipients to receive a number of critical services, including physician services, prescription drugs, dental treatment, and rehabilitation.[203] It should be noted that this option is threatened by recent federal regulatory changes eliminating TCM for children in foster care. The changes are being challenged by all states and some members of Congress.

Continuous coverage. There is wide variation among states in continuation of Medicaid coverage when children leave foster care to return to their families, or reach permanency through adoption or legal guardianship. New York is among the states that provide this important benefit. Lack of continuous coverage can prevent reunification of families whose children have intensive health or mental health needs, lead to re-entry into foster care, or result in poor outcomes for children after reunification.

Policy Options: States can fund and authorize medical services in accordance with 1, 2, or 3 of the following policies:

- State implements a comprehensive funding strategy that examines Medicaid spending per enrollee, strategic use of funding, use of state funds, provider incentives and interagency funding.
- State provides Medicaid targeted case management services for children in foster care.
- State continues Medicaid coverage for children leaving foster care to be reunified with their families.

7.4 Evidence-based mental health and trauma treatment.

Evidence-based mental health treatments and emerging first response strategies for children and youth who have experienced trauma can help improve outcomes for children involved with the child welfare system. In a study of nearly 700 foster care "alumni" living in the Northwestern United States, researchers found that nearly half had experienced a serious mental health problem such as depression, social phobia, panic disorder, post-traumatic stress disorder (PTSD), or drug dependency during the past year. Many of the alumni struggled with more than one of these problems. The rate of PTSD was twice that generally attributed to U.S. war veterans.[204] A study of placement stability in Illinois found that children with "externalizing" mental health diagnoses such as conduct disorders were 12 percent more likely than their peers to experience placement moves.[205] See Policy Area 2.6: Home and community-based services for families and children with mental illness, for a description of research-tested mental health treatments.

Research-tested mental health treatment includes:

- Cognitive Behavioral Therapy, which works with children and youth of many ages to improve anxiety, depression, and — if parents are involved — disruptive behaviors, attention deficit hyperactivity disorder (ADHD), and possibly PTSD.[206]
- Multi-systemic Therapy, which improves oppositional behavior, conduct disorder, sexual offenses, and substance abuse. It reduces criminal behaviors and out of home placements. The subject of multiple studies, the therapy has been proven primarily with males and adolescents.[207]

Evidence-based assessments and trauma-specific treatments being used by children's mental health practitioners include:

- Parent-Child Interactive Therapy,
- Trauma-Focused Cognitive Behavioral Therapy,
- Dialectal Behavior Therapy,
- Trauma Recovery and Empowerment for Adolescent Girls and Young Women, and
- Seeking Safety for Adolescents.[208]

Illinois legislation (2005 Ill. Public Act 004-0034, Ill. State Code: Sec. 5.25) requires that trauma services must be provided for every child in the care of the child welfare agency who needs them.

Elimination of harmful practices is necessary along with implementation of evidence-based treatment. The use of practices such as seclusion and restraint when not absolutely necessary has resulted in trauma, and in some cases, untimely death in residential and hospital-based mental health settings. A federally led initiative is

underway in eight states to eliminate the use of seclusion and restraint in residential facilities and hospitals. Massachusetts, Louisiana, and Hawaii are focusing specifically on eliminating the use with children. Both Massachusetts and Louisiana have reduced seclusion and restraints in institutions for children by 80 percent. In Hawaii, where restraints and seclusion are not widely used, the needs of children who have run away or assaulted are being addressed.[209]

Policy Options: States can promote evidence -based mental health and trauma treatment by adopting and funding the implementation of either or both of the following policies:

- Evidence-based mental health and trauma services are available for every child in foster care.
- Unnecessary use of seclusion and restraints and other practices that research demonstrates cause or heighten trauma for children are prohibited.

7.5 Medical and educational records (passports).

Safeguarding the medical and educational records of children in foster care and ensuring that their records follow them throughout their time in care can help improve child well-being. One study found that more than 30 percent of youth in foster care had eight or more placements with foster families or group homes. Sixty-five percent experienced seven or more school changes from elementary through high school.[210] As a result of changes in schools and health care providers tied to placement moves, available educational and health information about these children is often incomplete.[211] Misplaced, delayed, inaccessible, or incomplete educational records contribute to negative school experiences — including inappropriate programming, missed days, and delayed high school graduation.[212] Inadequate medical records can result in life-threatening health care crises for children in foster care. A federal study of Medicaid services for children in foster care in New Jersey found that caseworkers for half the children in the sample and the majority of caregivers did not receive the child's medical records or received only partial records.[213]

To enhance continuity of health care, several states have developed an abbreviated health record often called a medical passport. Held by the child welfare agency and the foster parent, the medical passport has the potential to facilitate the transfer of essential information among physical and mental health professionals. It provides a brief listing of the child's medical problems, allergies, chronic medications, and immunization data as well as basic social service and family history. Foster parents are instructed to keep this document for the child, bring it to all health visits, and ensure that health care providers update the information on the form. When the child

changes foster care placements, reunifies with his or her family, or achieves another permanent placement, the medical passport is transferred to the child's new caregiver. Computerized health information systems are also being developed in several states to make specific health information about children in foster care more readily accessible to practitioners and child welfare agencies, to safeguard the data despite changes in caseworkers and caregivers, and to ensure confidentiality of the information.[214]

Educational passports can help promote seamless educational transitions for children and youth when educational placement changes occur. In the Child and Family Services Reviews, the federal government rates availability of school records as one factor for judging how well a state is meeting the Child Well-Being Outcome for education. In 18 of the first 37 states reviewed, education records were missing from case files or had not been made available to foster parents.[215] The Fostering Connections legislation responds to this concern by requiring states to ensure that educational records are provided to a new school when children can not stay in the school in which they were enrolled when they were placed in foster care.[216]

Several states have enacted legislation aimed at improving records sharing and avoiding both delays in enrollment and uninformed educational programming. For example, Texas legislation (2005 Tex. Gen. Laws, SB 6, Chap. 268) requires the State Health and Human Services Commission to develop an educational passport for each foster child to include educational records, the child's grade-level performance, and any other relevant information. The child welfare agency is required to make the passport available to the person authorized to consent to medical care and to a health care provider if the information is necessary to the provision of medical care.

The courts have an important role to ensure that children in foster care receive needed and appropriate services and that health and education records follow a child. The National Council of Juvenile and Family Court Judges has developed a judicial checklist that court officials can use to monitor children's education needs and treatment. Checklists have been developed for use by judges in Alaska, California, District of Columbia, Idaho, New Mexico, New York, and Washington.[217]

Policy Options: States can promote record sharing by adopting 1, 2, 3, or 4 of the following policies:

- Medical passports are required for all children in foster care.
- Educational passports are required for all children in foster care.
- Computerized health information systems safeguard medical information about children in foster care.
- Courts monitor children's medical and educational needs and services.

Policy Area 7: Well-being of Children Who Experience Out-of-Home Placement Summary of Policy Options

Policy Area	Policy Options
7.1 Access to quality early care and education	Promote participation in quality early care and education among young children in foster care by adopting and funding the implementation of one of the following policies: • Participation is mandatory up to school age • Participation is mandatory for children ages three to five • Participation is available for children from birth to age three
7.2 Educational advocates or liaisons	Promote the availability of trained and informed educational advocates or liaisons by adopting 1, 2, or 3, of the following policies: • Kinship caregivers, foster parents or court-appointed special advocates have preference for appointment by the court as educational surrogate or advocate. • Educational advocates must be available within the child welfare system • Educational advocates must be available within the school system
7.3 Medical coverage	Fund and authorize medical services in accordance with 1, 2, or 3 of the following policies: • State implements a comprehensive funding strategy that examines Medicaid spending per enrollee, strategic use of funding, use of state funds, provider incentives and interagency funding. • State provides Medicaid targeted case management services for children in foster care. • State continues Medicaid coverage for children leaving foster care to be reunified with their families.
7.4 Evidence-based mental health and trauma treatment	Promote evidence -based mental health and trauma treatment by adopting and funding the implementation of either or both of the following policies: • Evidence-based mental health and trauma services are available for every child in foster care. • Unnecessary use of seclusion and restraints and other practices that research demonstrates cause or heighten trauma for children are prohibited.
7.5 Medical and educational records (passports)	Promote record sharing by adopting 1, 2, 3, or 4 of the following policies: • Medical passports are required for all children in foster care. • Educational passports are required for all children in foster care. • Computerized health information systems safeguard medical information about children in foster care. • Courts monitor children's medical and educational needs and services.

Youth in Transition to Adulthood

8

To ensure that the 20,000 young people aging out of foster care each year overcome the obstacles their neglect, abuse, and stays in state custody have caused, they must be assured the support and opportunities to succeed that other youth have.[218] Tragically, many of these young people experience a range of negative outcomes as they transition from state custody to adulthood — outcomes that impact their lifelong health, well-being, productivity, and contribution to society.

With educational achievement and opportunities lagging behind their peers, many young people leave foster care poorly prepared to succeed. A third of youth in foster care do not complete their high school degree. At age 19, only 18 percent of foster youth are pursuing a four-year degree, compared to 62 percent of their 19-year-old peers.[219] By their mid-twenties, about the same percentage of foster care alumni have obtained a high school degree as the general population, but most opt for a GED, a decision associated with fewer opportunities to obtain an advanced degree or generate equivalent income.[220] At age 25, less than three percent of foster care alumni in one study had completed a bachelor's degree or higher, compared to 24 percent of the general population.[221]

Youth transitioning to adulthood from foster care take many personal problems with them. One-third of 19 year old foster care alumni suffer from depression, dysthymia, post-traumatic stress disorder (PTSD), social phobia, alcohol abuse, alcohol dependence, substance abuse, or substance dependence.[222] At the same time, one-third of young

adults leaving foster care have no health insurance, a rate nearly double that of 18 to 44 year olds nationwide.[223]

Studies of young adult foster care alumni reveal that in addition to health care needs, these young people face significant economic hardships. More than one in five alumni experiences homelessness after leaving foster care.[224] A quarter of them are categorized as food insecure on a composite measure of food security. Of those who reported any income from employment during the past year, more than three-quarters earned less than $5,000, and 90 percent earned less than $10,000.[225]

The Fostering Connections legislation requires child welfare caseworkers to help youth make this transition to adulthood by working with the youth to develop a "personal transition plan" during the 90 day period immediately before they leave foster care. The plan must include specific options for housing, health insurance, education, local opportunities for mentoring, continuing support services, workforce supports and employment services. This requirement can help youth develop a more planful approach to transition from foster care, and can be supported by the following policy actions to help meet the permanency, health, education, and housing needs of youth aging out of foster care.

8.1 Foster care extended past age 18.

Research suggests that allowing youth to remain in foster care voluntarily after age 18 is an important policy option, particularly since many youth do not graduate from high school until after their 18th birthday. Youth remaining in state custody for an additional year are more likely to advance their education, have stable housing, stay out of the juvenile justice system, receive independent living services, and have access to health and mental health services.[226] Staying in care allows young people to access services and supports to an extent not offered after state custody ends. In addition, continued court jurisdiction of their cases can help monitor and improve their progress toward a successful transition.

Over half the states allow at least some youth to stay in care past 18. However, many states extend age limits only to 19 and set requirements for remaining in care that may be unrealistic for many foster youth. For example, in several states (including Pennsylvania), foster youth may remain in care only if they are enrolled in an educational activity (such as finishing high school or attending a postsecondary institution), or (in Ohio) if they have a special need or disability. Arizona, and DC allow youth to remain in care without any conditions. In Illinois, a young person can remain in foster care until 21 if the state finds that the health, safety, and best interest of the youth and public require continuation.

In 2008, Congress authorized an option for states to provide federal support to Title IV-E eligible youth in foster care until the age of 19, 20 or 21. In order to be eligible, youth must be completing high school or a GED program, be enrolled in post-secondary or vocational school, participate in an employment program, or be employed for at least 80 hours per month. Youth who are incapable of doing any these activities due to a medical condition are also eligible, as are youth who are adopted or in guardianship.

Policy Options: States can adopt one of the following policies to allow youth stay in foster care past age 21:

- Up to age 19, 20 or 21 for Title IV-E eligible foster and adoptive youth or youth in guardianship under the federal option:
- With state funding, support for non IV-E eligible youth
- With state funding, extend foster care assistance up to age 25 for all youth

8.2 Method of continuing participation in foster care after age 18.

States have several options for extending foster care to youth after age 18. Continuation can be automatic, or youth can be required to request an extension. Alternatively, states can implement a "return policy" for youth who leave foster care at age 18. In Kentucky, for example, policy allows emancipated foster youth who experience difficulties to return to state care, where they are ensured health insurance, housing, and continued support.

Policy Options: States can facilitate the process for youth to stay in foster care by adopting one of the following policies:

- Automatic continuation
- Opt-out, opt-in allowed
- Continuing court supervision

8.3 Medicaid eligibility.

To ensure that youth have access to medical care when they leave foster care, states should take advantage of the federal option that allows extended Medicaid coverage. Under the federal Chafee Foster Care Independence Act, states have the option to expand Medicaid eligibility to transitioning youth who were in foster care on their 18th birthday, are under age 21, and do not exceed income and asset levels as determined by the state. If states choose to take advantage of this option, their expenditures continue to be matched at their standard federal Medicaid matching rate.

Currently, at least 19 states (Arizona, California, Connecticut, Florida, Indiana, Iowa, Kansas, Mississippi, Nevada, New Jersey, Oklahoma, South Carolina, South Dakota, Texas, Utah, Colorado, Michigan, Georgia and Wyoming) have chosen to expand Medicaid eligibility. For example, Arizona has no income ceiling for foster youth to qualify for Medicaid, and Texas statutes require the state to provide uninterrupted Medicaid coverage to young people who age out of foster care at age 18 through the month of their 21st birthday.

Policy Option: States can adopt a policy that youth who are in foster care or were in care at age 18 are eligible for Medicaid coverage until age 21, regardless of whether they are receiving extended foster care assistance.

8.4 Educational assistance.

Providing tuition assistance helps youth in transition complete a higher level of education and prepares them for a more prosperous future. The Midwest Study of foster care alumni found that youth who remain in care past age 18 are significantly more likely to continue their education than those who do not.[227] To assist them, Congress amended the Chafee Foster Care Independence Act in 2001 to authorize the Educational and Training Voucher (ETV) Program for foster youth. Fostering Connections legislation extends eligibility for the ETV program to children 16 and older who exit foster to adoption or guardianship.[228]

Annual appropriations to help states pay for postsecondary education, training and related costs have totaled between $42 million and $47 million. Eligible youth may receive the lesser of $5,000 a year or the total cost of attending an institution of higher education. Students who have participated in the ETV program before their 21st birthday may continue to receive this education support up to age 23. Federal program guidelines call for former foster youth to apply for ETV funds in the state where they currently reside; however, many youth apply in the state where they were emancipated, resulting in confusion for states and recipients.[229]

In addition, an increasing number of states provide their own educational assistance. Florida, Georgia, Kentucky, Maine, Maryland, Massachusetts, Michigan, New Jersey, North Carolina, Oregon, Texas, Virginia and Washington have grant, scholarship, or tuition waiver programs for foster youth attending state-supported colleges and universities and allow youth adopted from foster care to remain eligible for their use.[230]

Some states have loosened restrictive educational conditions attached to aid. For example, recognizing how difficult it can be for foster youth to maintain full-time enrollment in educational activities while meeting their other survival needs, Florida has opted to allow for part-time attendance until age 24.

Policy Options: States can adopt a policy that youth in foster care and foster care alumni are eligible for educational assistance through 1, 2, or 3 of the following mechanisms

- Educational grants of $5,000, as allowed via Chafee federal funds
- Educational grants funded by state supplements to Chafee funds
- Tuition waivers for state-supported colleges and universities

8.5 Housing assistance.

To prevent homelessness and other housing issues that youth leaving foster care face, policymakers need to ensure that housing assistance is available. States may spend up to 30 percent of their federal Chafee Foster Care Independence Act funding allocations on room and board for former foster youth. At least ten states have opted to use the full 30 percent allowed.

States can take additional steps to support foster youth and alumni in meeting their housing needs. For example, California created a transitional housing program for foster youth with a dedicated funding stream for transitional housing for emancipated youth until age 24 (Cal. Ann. Welf. & Inst. Code, Sec. 11403.1-2). Connecticut provides a continuum of services until age 21 that includes a community housing assistance program with a housing subsidy and case management.

Policy Options: States can authorize and fund either or both of the following programs:

- Transitional housing programs
- Housing subsidies for youth

These programs can be made available to youth in the following age categories (in increasing order of youth affected):

- Up to age 21
- Up to age 24

8.6 Employment Readiness/ Assistance.

Youth exiting foster care to adulthood often have dismal employment outcomes. Their employment is often sporadic and seldom provides them with financial security. Along with their educational deficits and inability to rely on family for meeting basic needs, limited employment contributes to the serious economic hardship experienced by many young adults who transition from foster care to adulthood.[231] Many youth exiting foster care lack the skills and maturity to be successful in the adult workforce in part because they have not had employment role models while growing up or the employment connections that family can sometimes provide.[232] There is some evidence that targeted job training and readiness supports provided by using a multi-system approach may improve individuals' preparation for employment.

Five states (California, Illinois, Michigan, New York, and Texas) received federal grants from the U.S. Department of Labor's Employment and Training Administration (ETA) and contributed state matching funds to conduct demonstration projects designed to improve outcomes for youth exiting from foster care. States were required to target the city or county with the largest number of youth in foster care for the projects. The sites provided job preparation, college preparation, GED/basic education, life skills training, income support and other training and services. Sites varied in their services and activities, which included job-preparation and job-finding activities, transition counseling, internships, individualized job search and career preparation activities, tutoring, life coaching and mentoring. Although promising practices were developed across sites, outcomes for participants were difficult to measure and were mixed overall. The data showed that the longer youth received intensive services across multiple service systems, the more likely they were to achieve employment, a GED or diploma, or post-secondary education. In addition, program participants and evaluators reported that certain components contributed to readiness.[233]

Policy Options: States can authorize and fund employment readiness and assistance that feature 1, 2 or 3 of the following:

- An integrated multi-system wraparound approach to support youth while they acquire employment readiness skills.
- Staff specialists who work directly with youth.
- Long term, intensive services.

8.7 Permanent connections to committed adults

Social networks serve a number of important functions as youth make the transition into adulthood and independent living. Social ties provide young adults with emotional support; guidance on employment, education, and relationship issues; and assistance in times of emergency. Most young adults who are raised by their birth families have built-in, lifelong support networks of parents, siblings, extended family, and family friends. Such relationships, however, are not ensured for youth who have spent time in the foster care system. Hard work is often required to develop and maintain stable, permanent relationships for youth aging out of foster care. Efforts to link youth in foster care with caring adults who are able and willing to provide lifelong support and relationship must begin before the child approaches emancipation. Case workers, judges, caregivers and others must work deliberately with youth to develop a plan for connecting them to committed adults.

California has developed the most comprehensive policy framework for ensuring lifelong connections for young people in foster care. Landmark legislation (2003 Cal. Stats., AB 408, Chap. 813) requires the state to encourage the development of approaches to child protection that ensure that no child leaves foster care without a lifelong connection to a committed adult. For every child in care who is ten years or older, the court is required to determine whether the child welfare agency has made reasonable efforts to maintain relationships with individuals who are important to the child. Social workers and certain agencies, in specified circumstances, must make efforts to identify those individuals and to make efforts to maintain those relationships. County child welfare agencies are required to provide information to youth on maintaining important relationships. Training must be provided to county child welfare workers regarding the importance of maintaining child relationships with important individuals and methods for identifying those people (See Policy Area 3.1 Location and engagement of Kin). Individuals important to the child must be convened for key decision-making, including case plans for young people age 16 or older, and for the child's transitional independent living plan.

In Massachusetts, a statewide initiative called Lifelong Family Connections for Adolescents assists young people in foster care as they develop permanency plans. The program helps youth review their social connections to identify caring adults who are willing and able to make a lifelong commitment, provides relationship training for both youth and adults to promote a successful match, and offers ongoing support to youth and adults to help them identify community resources and address relationship issues.

Policy Options: States can promote permanent connections to caring kin by adopting and funding implementation of 1, 2, or 3 of the following policies:

- Child welfare agency is required to ensure that no child leaves foster care without a lifelong connection to a committed adult.
- The court is required to determine that the child welfare agency has made reasonable efforts to connect each child in foster care age ten or older with a caring adult.
- Child welfare caseworkers receive training regarding the importance of maintaining child connections with kin and methods for identifying a committed adult.

Policy Area 8: Youth in Transition to Adulthood Summary of Policy Options

Policy Area	Policy Options
8.1 Foster care extended past age 18	Adopt one of the following policies to allow youth stay in foster care past age 21: • Up to age 19, 20 or 21 for IV eligible foster and adoptive youth or youth in guardianship under the federal option: • With state funding, support for non IV-E eligible youth • With state funding, extend foster care assistance up to age 25 for all youth
8.2 Method of continuing participation in foster care after age 18	Facilitate the process for youth to stay in foster care by adopting one of the following policies: • Automatic continuation • Opt-out, opt-in allowed • Continuing court supervision
8.3 Medicaid eligibility	Adopt a policy that youth who are in foster care or were in care at age 18 are eligible for Medicaid coverage until age 21, regardless of whether they are receiving extended foster care assistance.
8.4 Educational assistance	Adopt a policy that youth in foster care and foster care alumni are eligible for educational assistance through 1, 2, or 3 of the following mechanisms: • Educational grants of $5,000, as allowed via Chafee federal funds • Educational grants funded by state supplements to Chafee funds • Tuition waivers for state-supported colleges and universities.
8.5 Housing assistance	Authorize and fund either or both of the following programs: • Transitional housing programs • Housing subsidies for youth These programs can be made available to youth in the following age categories (in increasing order of youth affected): • Up to age 21 • Up to age 24

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Policy Area 8: Youth in Transition to Adulthood Summary of Policy Options

Policy Area	Policy Options
8.6 Employment Readiness/ Assistance	Authorize and fund employment readiness and assistance that feature 1, 2 or 3 of the following: • An integrated multi-system wraparound approach to support youth while they acquire employment readiness skills. • Staff specialists who work directly with youth. • Long term, intensive services.
8.7 Permanent connections to committed adults	Promote permanent connections to caring kin by adopting and funding implementation of 1, 2, or 3 of the following policies: • Child welfare agency is required to ensure that no child leaves foster care without a lifelong connection to a committed adult. • The court is required to determine that the child welfare agency has made reasonable efforts to connect each child in foster care age ten or older with a caring adult. • Child welfare caseworkers receive training regarding the importance of maintaining child connections with kin and methods for identifying a committed adult.

II. SUPPORTIVE COMMUNITIES

Community Decision-Making Partners and Service Delivery

9

All families are dependent upon the services available in or near their communities to ensure the healthy development of their children. Child serving agencies and systems are likewise dependent upon community-based services to support parents, strengthen families and improve outcomes for the children they serve. In many communities, the necessary resources are unavailable to both families and the service delivery system. Lack of resources is a joint problem that requires a joint solution. The child welfare system alone cannot, and should not, create all the needed resources within communities in which families and children live. Conversely, communities are equally unable to solely ensure the availability of all assets critical to families, such as quality early care and education programs, family support centers, community recreation, out of school time programs, safe and affordable housing, and public transportation.

As a result, a shared need and responsibility exist between the agencies that rely on services to assist families and the families in communities that access those resources. In order to meet this shared responsibility, a partnership is required to build resources. More than twenty years ago, the U.S. Advisory Board on Child Abuse and Neglect issued a report detailing a crisis in the child protection system resulting from overwhelming demands and insufficient responses. The Board concluded, "…[I]t has become far easier to pick up the telephone to report one's neighbor for child abuse than it is for that neighbor to pick up the telephone to request and receive help…If the nation ultimately is to reduce the dollars and personnel needed for investigating reports, more resources must be allocated to establishing voluntary, non-punitive

access to help."[234] The Board's proposal was a child-centered, neighborhood-based approach to supporting families and ultimately, protecting children.[235] Yet, a strong system of community-based supports has been slow to develop, even though evidence demonstrates that "neighbors can collectively provide strong support to children and parents and that such support, when available on a regular basis, may reduce the incidence of violence."[236]

Community supports are best designed and developed by and through the community residents that will ultimately access the resources. A number of federal, state and locally supported initiatives have provided strong demonstrations of the shared responsibility and need that is served by the development of community-decision making collaborations. The Safe Kids/Safe Streets Initiative, funded by the federal Office of Juvenile Justice and Delinquency Prevention, succeeded in building broad-based collaboratives focused on child abuse and neglect issues in five very different communities. These five collaboratives enabled their communities to forge partnerships across agencies and engage a broad range of stakeholders in developing a plan for addressing child abuse and neglect along with the corresponding resources.[237] The State of Maryland codified collaboration entities and provided funding to implement a local interagency service delivery system for children, youth, and families.[238] Maryland's local collaboratives, made up of residents and agencies in each county, have effectively worked to identify local needs and develop resources to meet those needs. The District of Columbia has established and supported neighborhood collaboratives in which individuals and organizations come together in each neighborhood to form a coordinated network of services and supports for children and families. The District collaboratives have several functions; they provide direct services, coordinate services, develop community capacity, monitor progress, and coordinate resource development.[239] In all three examples, local residents partnered with agency representatives to collectively meet their shared responsibility to families and communities.

A study of the effectiveness of community decision-making partnerships identified the key elements as: strong resident and community involvement; stable leadership; private sector and business involvement; and partnerships with an appointed or elected branch of government. The study further determined that effective collaboratives were:

- Developing new and innovative services and strategies,
- Improving access to services,
- Providing information and connecting residents to services, and
- Facilitating public agency system connections to natural helping systems.[240]

Community level collaboration provides an opportunity to meet two vitally important objectives: to strengthen the continuum of services available to child welfare agencies and to provide resources for residents outside of the child protection system.

9.1 Capacity for developing comprehensive, community-based services.

To be active and effective partners in the healthy development of the community's children, local collaborative organizations require investment in administration, technical assistance and dedicated funding for services identified by local collaboratives, including:

- tools to identify needed resources (such as community mapping, resident surveys, and self-assessments),
- assistance in developing community mobilization and engagement strategies,
- leadership development capacity, and
- funding for administration and services.

Multi-year trend data and anecdotal evidence suggest that community based decision-making partnerships can contribute to the improved well-being of children, families and communities.[241] However, research on the efficacy of community collaboratives found that providing technical assistance to the local communities is vital to the success of the collaboration in its effort to improve child well-being.[242]

Over the past twenty years, many local collaboratives have developed that focused on a broad agenda of child well-being while also creating resources that enhanced the service delivery system of child welfare agencies. In 1997 West Virginia supported the ability of families to care for their children through the development of Family Resource Networks (FRNs). The early FRNs were created as a statewide network of community organizations that were composed of residents and providers and served as the coordinating and planning bodies for their communities' service system for children and families. The FRNs conducted needs assessments, developed local plans, identified system improvements, and evaluated results. The state established a cross-agency fund to support the FRNs that began with Medicaid and AFDC, in addition to redirected state funds.[243] Since 1994 the Oregon Commission on Children and Families has continuously sponsored local, coordinated, comprehensive services for children and families through a system of local collaboratives supported by state general funds.

The Family Connection Partnership in Georgia is a nonprofit organization that supports a network of 159 collaboratives throughout the state. The collaboratives are public-private partnerships made up of agency and community representatives that

develop, fund, implement and evaluate a comprehensive interagency plan for services to children. The Family Connection Partnership provides technical assistance to the local collaboratives on results-based facilitation, new coordinator training, cultural responsiveness, board development, strategy development, contract reporting, financial reporting, finance, funding, evaluation, plan review, family engagement and collaboration. In 2006 they implemented *Family Connection Standards for Excellence in Collaboration and Community Decision-Making* establishing a system of assessment and standards for the performance of the collaboratives.

While financing the services planned or coordinated by the collaboratives is essential to the development of community resources for child welfare agencies and families to access, it is important to note that research on effective community decision-making found that influencing funding was more important to success than control of the funding.[244] In either case, identifying dedicated funding streams has proven challenging due to the categorical nature and limited availability of financial support. As far back as 1992 it was noted that the term "categorical funding" had become "synonymous with all that is wrong with current social services"[245] because the result of such targeted funding was a fragmentation of services. Since the 1980's there have been efforts to decategorize funding streams in order to serve children and families more holistically. The most notable effort is the Child Welfare Decategorization Project in Iowa (also known as "DeCat"), which began with 30 funding streams brought together at the county level. Over the years the money has decreased and become more restrictive, but the local boards continue to plan, coordinate and distribute several funding sources including federal juvenile justice, TANF, and Promoting Safe and Stable Families dollars.[246] Another approach is in Virginia where the pooling of eight funding streams was legislatively mandated through the "Comprehensive Services Act for At-Risk Youth and Families". These funds are allocated to the localities through local interagency teams to coordinate services for high-risk youth.[247]

Policy Options: States can authorize and fund 1, 2, or 3 of the following capacity-building supports:

- Multi-year financial investment in administration
- Technical assistance
- Dedicated funding for services identified by local collaboratives

9.2 Monitoring based on outcomes and service quality.

One important policy objective for community collaboratives is determining the results to be achieved and the measurement of their progress, because what gets

measured gets done. However, what is measured, how it is measured and why it is measured all need to be carefully considered to ensure that the goals are supported by data readily available at the state and local levels. The most effective results-based systems measure broad population level outcomes that ensure contributions from all sectors and improve the overall result.[248] State outcomes should be linked to measurements at the community level[249] because it is the responsibility of the state and community to work together to meet the challenge of helping all youth become successful adults. For example, the state of Vermont focused on supporting community-based planning designed to improve outcomes for children and families and subsequently experienced improvements in the rates of adolescent parenting, juvenile delinquency, and child abuse.[250]

Policy Option: States can require that a collaborative process is used with local partners to establish results, collect data, report on outcomes and create accountability

9.3 Community-based doorways to services.

Communities and government need to work together to ensure that young children have a good beginning and that they are successful in school and ready for the future. State agency collaboration with neighborhood groups opens up many new avenues for community-based services to achieve positive outcomes. Community-based services are found in the neighborhoods where children and families live and can be provided by grass-roots groups, large community-based organizations or government sponsored programs. The key opportunity of coordinated services at the community level is the prospect of reducing or eliminating fundamental barriers to the delivery of services to children and families both inside and outside the child welfare system. The problem created by categorical funding is only one part of the "iron triangle of specialized funding, specialized professional purviews, and specialized agency organization … that delimit and divide solutions to family problems rather than encourage broader and more flexible responses".[251] Creating local services gives rise to potential new strategies for child welfare agencies to effectively and comprehensively support children and families in their communities by addressing the range of needs families display.

Service accessibility is defined by the following characteristics: coordinated or integrated eligibility determination and application for assistance, collocated service delivery systems, coordinated or integrated case management, and service delivery oriented toward customer satisfaction.

Coordinated or integrated eligibility determination and application for assistance is a goal of many human services agencies. Washington State conducted a survey that found families did not complete applications for public benefits to which they were entitled

because the process was too cumbersome and confusing. As a result, the State Department of Family and Health Services now has a single online application and eligibility determination process. While a number of states have developed some form of multi-program application, the process often remains lengthy and difficult. Vermont's approach has been to make a multi-program online application accessible through community based centers to both streamline the process and create linkages with existing services. The application covers approximately 12 different benefit programs including TANF, food stamps, child care, and Medicaid.[252]

Collocated services reduce the number of entry points a family must navigate in order to gain access to currently available programs. The Annie E. Casey Foundation's Family to Family initiative found that a neighborhood location that co-locates child welfare and community services encourages the development of long-term supports for families and improves access to services.[253] Examples of community doorways include Louisville, Kentucky where leadership noted that co-location of CPS workers dramatically changed the perceptions of families regarding services and supports available to them within the community and through CPS.[254] Massachusetts formed "Patch Teams" that collocated child welfare staff in family support centers where a wide array of family assistance is provided through a shared decision-making, community-based service model.

Nebraska created community based doorways through Family Resource Centers. The centers provide social and emergency services such as: Family Preservation case coordination; rent assistance; emergency food; household budgeting workshops; home weatherization; HUD-certified mortgage counseling; Head Start; GED, English as a second language, adult basic education tutoring, computer skills training; education and job skills development, work-related clothing or tools; computer learning lab; one-on-one tutoring, academic support, mentoring, vocational exploration; child care; community gardens; summer camp scholarships; back-to-school fairs; and linkage to other community resources and other supports for families and children. These examples demonstrate the value of in order to provide comprehensive services in a seamless fashion in communities.

Coordinated or integrated case management refers to a team approach where services from various agencies are effectively coordinated in a family or child's service plan. One study found that integrated case management resulted in better coordination among staff, more complete service integration and improved client outcomes.[255] The Maine Children's Cabinet launched Integrated Case Management (ICM) that brought together child welfare, domestic violence, mental health and substance abuse through a state funded initiative. In an early example of child welfare and domestic violence coordination Oregon located contracted domestic violence specialists in all local child welfare offices.[256]

Service delivery that focuses on customer satisfaction would strive to address the needs of customers and the quality and accessibility of assistance. Research on the benefits of customer satisfaction goals in the private sector and their application to the public sector suggests that there are important lessons to be derived from a customer service orientation. At the most basic level, both human services staff and the families they serve stand to benefit. Human services workers have a demonstrated desire to be "helpers", but there are very few opportunities for them to see the clear benefits of the help they provide. By creating a customer service orientation with a defined mechanism for obtaining feedback from customers, workers would have an opportunity to feel and hear the impact of their efforts. On the other hand, families who are customers would benefit from motivated workers. A customer service delivery system has the potential to achieve: better informed resident/consumers; improved quality of available resources; and greater access to an appropriate array of services.[257] A control group study demonstrated that Montgomery County, Maryland's Department of Health and Human Services improved customers' satisfaction with service delivery by implementing a customer service approach within a center providing family economic support and housing stabilization assistance. Key features included designated customer service staff that helped consumers navigate the application, eligibility determination and referral process; customer service training for all staff of the service center; surveys and other customer feedback; and physical improvements intended to make the facility more customer-friendly.[258] Although customer satisfaction strategies have not been rigorously tested with child welfare services, Montgomery County is expanding their approach to additional centers that provide family economic support and housing assistance.

Policy Options: States can promote service accessibility by adopting 1, 2, 3, or 4 of the following service delivery mechanisms:

- Coordinated or integrated eligibility determination and application for assistance;
- Collocated service delivery systems;
- Coordinated or integrated case management; and
- Customer service oriented service delivery

Policy Area 9: Community Decision-Making Partners Summary of Policy Options

Policy Area	Policy Options
9.1 Capacity for developing comprehensive, community-based services	Authorize and fund 1, 2, or 3 of the following capacity-building supports: • Multi-year financial investment in administration • Technical assistance • Dedicated funding for services identified by local collaboratives
9.2 Monitoring based on outcomes and service quality	Require that a collaborative process is used with local partners to establish results, collect data, report on outcomes and create accountability
9.3 Community-based doorways to services	Promote service accessibility by adopting 1, 2, 3, or 4 of the following service delivery mechanisms: • Coordinated or integrated eligibility determination and application for assistance; • Collocated service delivery systems; • Coordinated or integrated case management; and • Customer service oriented service delivery.

III. EFFECTIVE SYSTEMS

Effective Assessment and Case Planning

10 Decision-Making Systems

10.1 Individualized and comprehensive assessments and planning.

An essential step to determine a child's safety, cognitive physical, emotional, and social development is a comprehensive assessment and corresponding plan of services.

A comprehensive assessment is necessary to effectively determine the child's

1. safety;
2. cognitive, social, emotional and physical development; and
3. the nurturing capacity of their family environment.

Studies profiling the health status of children and adolescents entering foster care demonstrate high rates of acute and chronic medical problems, developmental delays, educational disorders and behavioral health conditions,[259] finding that children in foster care are almost four times as likely as other children to have a disability.[260] It is clear that periodic health and mental health assessments of children in foster care can minimize problems and ensure that the child's needs are met, particularly when conducted at the time of initial placement and any changes in placement, as recommended by the Child Welfare League of America-American Academy of

Pediatrics standards on health care for children in foster care. As of 2002, fewer than half of state child welfare agencies reported having adopted these standards.[261]

Individualized child assessment: Determining the safety, well-being and developmental status of children involved in the child welfare system is necessary to identify the appropriate response and the services they need. Further, to achieve the healthy development of children in the child welfare system, a comprehensive assessment is necessary to effectively meet their critical social, emotional and physical needs. An assessment should include a family assessment that identifies the assets and challenges within the child's environment together with an assessment of the child's':

- Medical (Pediatric developmental assessment);
- Dental;
- Mental health; and,
- Cognitive/educational development.

The Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program is a part of the Medicaid program that finances pediatric services and is mandatory for children in federally assisted foster care. EPSDT is the primary source of health care funding for children in foster care since the majority of child welfare agencies lack independent financing for primary health services. EPSDT is especially critical, since treatment of diagnosed conditions is both mandatory and eligible for federal Medicaid reimbursement.

Programs that involve interdisciplinary teams, have specific settings prepared for initial foster care screenings, rely on EPSDT-trained professionals, have presumptive Medicaid eligibility, and provide enhanced rates for EPSDT screens on foster children appear to ensure the most comprehensive and consistent quality of care.[262]

EPSDT programs developed in Oregon and West Virginia incorporate the use of screening tools that include mental health and substance abuse, can be rapidly administered, and provide immediately available results findings.[263] HealthWorks of Illinois, implemented by the Department of Children and Family Services in collaboration with the Department of Public Aid and the Department of Human Services, uses a community-based approach to serve all children in custody. Children are screened within 24 hours of entry and receive a comprehensive evaluation within 21 days. The program ensures ongoing comprehensive health care, including access to specialized services, and documentation of health care history through a Health Passport.[264] In Ohio the Thomas W. Blazey Diagnostic Center is a one-stop clinic where children receive a complete physical examination at the time of placement and follow up assessments occur upon any placement change and prior to discharge. The center houses medical, dental and psychosocial services.[265]

Educational assessments are mandated through Part C and Part B of the Individuals with Disabilities Education Act (IDEA), a federal law established to ensure that all children with disabilities receive a free appropriate public education. IDEA requires states to "identify, locate, and evaluate all children with disabilities, aged birth to 21, who are in need of early intervention or special education services".[266] Part C, which focuses on early intervention, applies to children birth to 3 years of age, and Part B, which addresses special education, targets children 3 years old and above. As of 2003, the Child Abuse Prevention and Treatment Act (CAPTA) requires that states have procedures to refer children who are the subject of an abuse or neglect referral and under the age of three to the early intervention services funded by Part C.[267] However, partnerships between Part C providers, Part B special education programs and child welfare agencies have generally been inadequate to meet these requirements. Massachusetts has piloted the Early Childhood Linkage Initiative designed to address this mandate and create a partnership between child welfare and early childhood services. In the first three years, the Initiative found that 74 percent of children assessed were eligible for services under the state's criteria, and 49% had an eligible delay under federal requirements.[268]

Comprehensive family assessments: A comprehensive family assessment provides information about the child's home and community that is vital to understanding his/her health and developmental progress as well as information about the family's strengths, needs and resources for nurturing the child. This assessment must examine:

- Safety and risks (including domestic violence) within the home,
- Parental mental health,
- Substance abuse issues, and
- Economic and material well-being (housing stability, food security, etc.).

The federal Administration for Children and Families developed guidelines for comprehensive family assessments noting that "If comprehensive family assessment is not undertaken as part of developing the service plan, we often miss the opportunity to develop interventions that contribute to lasting change".[269]

The Illinois Department of Children and Family Services produced a comprehensive family assessment tool for child welfare, which includes a set of questions concerning changes in the child's life during the past year, such as: victimization/neglect, death of a family member, new school, lost relationship, serious illness/injury, incarceration of a parent, parental unemployment, economic loss, change of residence, and witness of a violent crime [270]

In El Paso County, Colorado, the Department of Human Services' child welfare program and the family economic support program collaborated to address child safety and family poverty regardless of which program came in contact with the

family. As a result of a broad range of reform activities and a shared vision by both programs, a comprehensive assessment was developed to ensure that family income and child protection were effectively addressed.[271] (See also Strong Families A6)

The Family Program in Westchester County, NY is a collaborative effort between the Westchester Institute for Human Development and the Westchester County Department of Social Services that is designed to meet child welfare permanency goals by providing developmental and mental health assessments and services to all children in family foster care, their birth parents and their foster families. The initial intake assessment consists of a comprehensive developmental assessment for the child and a functional assessment of birth parents. Based on the results of the intake assessment, other evaluations are completed as necessary by members of the child development team including developmental pediatrics, child psychiatry, a psycho-educational specialist, speech/language pathology, occupational and physical therapy, and audiology.[272]

Policy Options: States can enhance assessments and planning by adopting one or both of the following policies:

- EPSDT include IDEA Parts B and C evaluations and thorough mental health assessments
- Comprehensive family assessment is required, including safety and risk (including domestic violence), mental health, substance abuse, and economic and material well-being (housing stability, food security, etc.)

10.2 Family Team Meetings.

Successful case plans for children must include information from both a comprehensive assessment and the engagement of family members. Family Team Decision Making, which is also known as Permanency Team Meetings, Family Team Meetings and Family Group Decision Making, is a method used by child welfare systems to create a team meeting approach with families. These teams make critical decisions jointly by identifying family strengths and needs and developing individualized plans. Evaluations of team meetings with families have demonstrated improved outcomes for children and greater satisfaction by both workers and family members.[273, 274] In cases where children were in out of home placement, the meetings helped to keep the children connected with their family. The service plans that result from the meetings are not only reliant upon resources in the family's community, but were fully understood and supported by all participants. Family meeting approaches are especially effective for minority families. In one study, African American children went home in 33 percent of cases with a team meeting, and Hispanic children in

39 percent of cases, compared to 13-14 percent of cases using traditional services. Relative placements increased from 29 percent to 45 percent following the team meetings.[275]

Family team decision-making is more effective when caseworkers begin by helping families structure the team and develop a full array of members, including extended family, other agencies and informal community resources. A study of one FGDM approach found that when the teams were strong children were more frequently placed with relatives, had shorter stays in care and were more likely to return to their families compared to traditional services. Children also reported to be less anxious and more adjusted when their families participated in an FGDM conference. Parent or caregiver attendance almost uniformly resulted in a decreased likelihood of changing placements.[276]

The Federal government recognized the importance of family team meetings when it authorized the Family Connections grants, a $15 million per year competitive grants program open to local, state and tribal child welfare organizations, as well as non profit organizations that serve foster and kinship families. Family group decision making meetings are one of the eligible activities supported through these grants.[277]

The Durham County, North Carolina Department of Social Services, a Family to Family site, was the recipient of a 2003 Best Practices award for their implementation of and commitment to Family Team Decision-Making. In describing their efforts Durham County highlighted the importance of including family and community with agency staff and professionals. This created a common frame of reference and a shared vested interest in the family's success, to which the decline in foster care placements was attributed.[278]

Recognizing the value of the family team approach, the Kansas legislature acted to provide the authority for the development of Family Group Decision Making (FGDM). The legislation encourages the use of FGDM in individual cases, requires the attendance and participation of certain professionals, and requires that all participants be notified of FGDM and the plan resulting from the meeting.[279]

Policy Options: States can promote family team decision making for children and families involved in the child welfare system by adopting 1, 2, or 3 of the following requirements:

- Required at periodic and routine intervals
- Required for all placement changes
- Required at the time of removal

10.3 Poverty exemption.

Children who live in extreme poverty are viewed as our nation's most vulnerable population, due to the stresses on their families and the fragility of their living circumstances. Economic hardship is one of the key factors thought to be associated with reports of child maltreatment, and with child neglect in particular.[280] Although correlational analyses suggested associations between poverty and substantiated child neglect, the conclusions of a recent report supported previous research findings that poverty alone is not a predictor of neglect.[281]

Nevertheless, when dealing with extremely poor families who are the subject of a report of alleged child abuse or neglect, workers frequently confront two difficult and equally unappealing choices: leave the child in apparent deprivation or remove the child and inflict the emotional trauma of separation. While most practitioners agree that children should never be separated from their families solely due to economic deprivation, the boundaries between some forms of child neglect and poverty are difficult to establish. Some state statutes explicitly provide for a "poverty exemption", a provision in the child abuse and neglect statute that declares a parent's financial inability to provide basic necessities for children does not, in of itself, constitute child neglect. Eleven states have promulgated such laws, however only West Virginia and Wisconsin subsequently developed dedicated state funding for the purchase of concrete services. In both instances, the child welfare agency is equipped with staff, funding and community referrals to address family needs in cases that are screened out for abuse or neglect.

Given existing mandatory reporting laws which require certain professionals to report suspected child abuse or neglect, it is important to educate mandated reporters so that they are able to distinguish between neglect and economic insufficiency in order to make appropriate reports or referrals for community services. A recent Government Accounting Office (GAO) report noted that the top three sources of reports to child protective services hotlines in 2003 were educational staff, law enforcement officials, and social services personnel, with the last two having disproportionate contact with low-income individuals.[282] Training reporters could help child welfare agencies reduce inappropriate neglect referrals and redirect families to appropriate services and supports. In addition, accountability systems allow agencies to examine the number of cases or types of services provided to ameliorate family poverty. This will give the agency the capacity to analyze and understand the relationship between poverty and allegations of child neglect, services provided and referrals or re-referrals.

Policy Options: States can promote a poverty exemption by adopting one of the following policies (listed in increasing order of effectiveness), and authorizing and funding corresponding services:

- Poverty exemption only
- Poverty exemption combined with funding for concrete supports
- Poverty exemption, funding for concrete supports, and training of mandated reporters to reduce "poverty-only" referrals and encourage linkages of families with appropriate resources

10.4 Multiple response system.

Children who are reported as neglected make up two-thirds of the cases screened in after a protective services investigation, even though many of these cases may be considered low risk and could benefit from community supports. Most child welfare agencies lack an intervention specific to these families and apply the same approach that is used for the most serious neglect or abuse cases. In response to this problem many agencies are now undertaking steps to develop differential approaches to address the needs of low-risk families that are screened in for potential risk of harm to the child. This multiple response system needs to include several key elements:

- Identification of low-risk families and non-investigatory response;
- Omission of the name of the alleged perpetrator in low-risk cases from the central child abuse registry;
- Provision of voluntary family supports and connection with community resources for low-risk families;
- Adequate and available network of community resources and supports for families;
- Required, available and ongoing training to implement system

The American Humane Association defines differential response as "an approach that allows child protective services to respond differently to accepted reports of child abuse and neglect, based on such factors as the type and severity of the alleged maltreatment, number and sources of previous reports, and willingness of the family to participate in services".[283] Differential response is also known as "dual track", "multiple track", or "alternative response". There are variations across the country in the implementation of a differential or alternative response approach, but in most instances the child welfare agency has developed an assessment of family needs, separate from the child protection system, with a corresponding program for providing services or community referrals to address those needs. A five year evaluation of Missouri's differential response program found that:

- The percentage of reported incidents in which some action was taken increased.
- Child safety was not compromised, and in certain types of cases was improved.
- In cases where child safety was threatened, children were made safer sooner.
- Recurrence of child abuse and neglect reports decreased.

- There was greater utilization of community resources.
- Cooperation of families improved.
- Families were more satisfied and felt more involved in decision-making.
- Workers judged the family assessment approach to be more effective.[284]

Minnesota has demonstrated equally impressive outcomes in the evaluation of their differential response program after three years.[285] An interesting finding in a study of California's differential response approach was a review of cases by professionals, both inside and outside of the child welfare agency, to determine how the system would respond under a differential response approach. Under the traditional system about 8% of the cases are screened in for risk of harm and provided services. However these professionals reported that 94% of the cases would receive services appropriate to their level of risk and need under a differential response system.[286]

According to a 50 state survey, conducted jointly by the Child Welfare League of America and the American Human Association, approximately 16 states are at varying stages of implementing a differential response approach.[287] California has implemented a three path approach to differential response piloted through the Breakthrough Series Collaborative process that documented the successes and challenges through an intensive testing process.[288] Families who are reported for neglect or abuse without an allegation or indication of harm, or risk of harm, would be formally referred for community assistance. Where the report and the assessment indicate a low to moderate risk of harm to the child, the case would be opened with child welfare and services provided through a partnership with community services. In the third path, where the risk of harm is elevated, families would be served through a traditional child welfare approach.

Policy Option: States can require a multiple response system for child abuse and neglect reports that are screened in and accepted.

Policy Area 10: Effective Assessment and Case Planning Summary of Policy Options

Policy Area	Policy Options
10.1 Individualized and comprehensive assessments and planning	Enhance assessments and planning by adopting one or both of the following policies: • EPSDT include IDEA Parts B and C evaluations and thorough mental health assessments • Comprehensive family assessment is required, including safety and risk (including domestic violence), mental health, substance abuse, and economic and material well-being (housing stability, food security, etc.)
10.2 Family Team Meetings	Promote family team decision making for children and families involved in the child welfare system by adopting 1, 2, or 3 of the following requirements: • Required at periodic and routine intervals • Required for all placement changes • Required at the time of removal
10.3 Poverty exemption	Promote a poverty exemption by adopting one of the following policies (listed in increasing order of effectiveness), and authorizing and funding corresponding services: • Poverty exemption only • Poverty exemption combined with funding for concrete supports • Poverty exemption, funding for concrete supports, and training of mandated reporters to reduce "poverty-only" referrals and encourage linkages of families with appropriate resources
10.4 Multiple response system	Require a multiple response system for child abuse and neglect reports that are screened in and accepted.

Monitoring and Oversight Systems

11 Accountability Systems

11.1 Child welfare performance goals.

The goal of child well-being is the concern of all stakeholders, but until recently the approaches to developing performance measures to determine progress by child welfare towards that goal were seen as either adversarial or cloaked in secrecy. The federal Child and Family Services Review (CFSR) require the engagement of stakeholders in the performance review process. This federal requirement has the potential of creating "an outcomes-focused approach to accountability [that] can free public agency administrators and managers to pursue more effective performance with other partners rather than having to restrict information, plan in isolation, and defend agency deficiencies".[289] An example of engaging stakeholders in the development of a reform plan is Alabama's settlement agreement that required sweeping improvements in child welfare. Through the agreement and as part of the CFSR process, Alabama's Department of Human Resources engaged private citizens, professionals, families and agency partners in the development and implementation of the state's child welfare improvement plan. As a result of these efforts, in 2007 the 19 year old law suit was dissolved based on the agency's substantial compliance with all goals to ensure the safety of children in its care.[290]

In an example created by the legislature, the Iowa Department of Human Services is required to develop an outcomes-based system to measure safety, permanency and well-being through a stakeholder panel that both participates in the design and the monitoring.[291]

Policy Options: States can mandate that child welfare performance goals are clearly and publicly developed, articulated and reported

11.2 Data monitoring, analysis, and reporting.

Child and family outcomes are the primary focus of the child-serving agencies, yet data collection systems are not comprehensive and the resulting information is not widely shared. Accountability systems are vital in holding agencies responsible for producing targeted outcomes, through clear measures that demonstrate an impact on the goals.[292] California legislatively mandated all 58 counties to measure progress towards identified child welfare goals with 14 performance indicators, such as: measuring the number of children who are in foster care, the rate of recurrence of maltreatment of children in foster care, the number of placements of a foster child, length of time to reunification with birth parents and the rate of adoption.[293] Counties receive quarterly data reports on their outcomes in the areas of safety, permanency and well-being of children and families who come into contact with the child welfare system.

Policy Option: States can mandate that data are monitored, analyzed, and reported to hold child welfare systems accountable for improving all outcomes, including: child safety, permanence, and well-being; family well-being; child welfare agency performance; individual program performance; and court performance.

11.3 Performance-based contracting.

Improving outcomes for children is not solely the responsibility of the agencies it is a responsibility that is shared with the private organizations that provide specific services through contractual relationships with the agencies. Nevertheless, it is uncommon for child welfare agencies to hold providers accountable for the well-being of the children they jointly serve. One successful approach has been performance based contracting, which is generally defined as contracts between the agency and private providers that:

- Emphasize results related to output, quality, and outcomes rather than how the work is performed,

- Have an outcome orientation and clearly defined objectives and timeframes,
- Use measurable performance standards and quality assurance plans, and
- Provide performance incentives and tie payment to outcomes.[294]

Performance based contracting in child welfare has resulted in: increased permanency; increased stability of permanency; increased stability of placements; decreasing caseloads; and reinvestment of resources.[295] The primary example of performance based contracting remains the Illinois Department of Children and Family Services (DCFS). DCFS has consistently improved permanency for children and families by aligning results with the financial interests of private providers. The agency also made significant investments in activities by the providers that would support permanency through staff positions; service dollars to ensure resources both at the time of placement and after reunification; and the flexibility to use administrative funds to support different models.[296]

Policy Option: States can mandate that performance-based contracting is required, monitored, and enforced to hold private providers accountable for improving child well-being, safety and permanence.

11.4 Quality Service Reviews.

Determining the well-being of children and families being served by child welfare agencies can be difficult since much of the information is contained in case files and in the experiences of the people involved, not in data collection systems. Therefore it is necessary to use qualitative as well as quantitative measures that include:

- An adequate number of cases reviewed;
- Reviews that are both statewide and local;
- A routine and systematic review process;
- Identification of performance issues, barriers, and strategies for improvement;
- Routine and public reporting of findings and recommendations

Quality Service Reviews (QSR) provide a qualitative method for assessing the service system's ability to respond to the individual needs of the children and families they serve through interviews and a review of case files.[297] The protocol involves a series of structured interviews with key information resources in two areas: Child and Family Status, and System Performance. The sources include case files as well as individuals involved in a case including children, parents, foster parents, other family members, therapists, teachers, and caseworkers. The interview team is trained to assess the information received and use it to determine a score of system performance based upon a scale. The process of quantification combines case reviews by all interviewers and reviewers through a group resolution process to produce an overall system score.

Approximately 15 states have implemented a quality assurance process that relies on case service reviews, including Utah. Utah has established a quality improvement system that includes clear outcomes and indicators published in the state's strategic plan which are regularly tracked and reported. The information analyzed as part of this system includes case reviews conducted in teams with stakeholders. The quality improvement process in Utah has led to changes in practice, improvements in documentation, policy changes and the development of new resources.[298] As determined by their QSR the overall system performance score went from 41.6% to 84.2% in five years.

Policy Option: Quality Service Reviews that effectively examine practice are required and supported.

11.5 Independent ombudsman office or other independent advocate.

When families and children experience frustrations or problems with the child welfare agency there are few avenues for resolution, this can lead to unsuccessful service plans, disrupted placements and communication barriers that prevent progress towards the family and child's goals. An ombudsman or child advocate office is one effective approach to resolving complaints from citizens and professionals regarding the manner in which the agencies are serving children. The American Bar Association (ABA) defines "ombudsman" as "a government official who hears and investigates complaints by private citizens against government agencies"[299] The ABA recommends the following critical elements of an ombudsman office:

- Full independence from the agency in which the ombudsman operates.
- Qualified staff—that is, legal experts to investigate and substantiate rights violations, social services experts to monitor and evaluate the adequacy of treatment, and educational experts to determine the effectiveness of academic and vocational programming.
- Sufficient funding and resources.
- Sufficient statutory authority to carry out investigations and mandate improvements.
- Ready access to youth, documents, records, and witnesses, in addition to subpoena power.
- Good-faith immunity from civil liability.
- Assurance that retaliation against a complainant in any form is prohibited.
- Lack of interference by officials or administrators of the agency or service provider that is the subject of the complaint.

Approximately 27 states have a children's ombudsman, the majority of which were established through legislative action.[300] The first of these efforts, the Rhode Island Office of the Child Advocate, was created to protect the legal rights of children in the care of the state through: the review of policies, procedures and legislation; investigation of complaints and child fatalities; recommendations for system wide reform; and monitoring of foster homes and institutional facilities. The New Jersey Office of the Child Advocate has subpoena power and the ability to bring legal action, which is the widest authority of the ombudsman offices nationally. A study of the Children's Ombudsman in Michigan determined that through the investigation of complaints changes occurred in the case management, child protective services investigations and service provision within the child welfare system.[301]

Policy Option: States can mandate oversight of individual treatment through an independent ombudsman office or other independent advocate.

Policy Area 10: Monitoring and Oversight Systems Summary of Policy Options

Policy Area	Policy Options
11.1 Child welfare performance goals	Mandate that child welfare performance goals are clearly and publicly developed, articulated and reported)
11.2 Data monitoring, analysis, and reporting	Mandate that data are monitored, analyzed, and reported to hold child welfare systems accountable for improving all outcomes, including: child safety, permanence, and well-being; family well-being; child welfare agency performance; individual program performance; and court performance.
11.3 Performance-based contracting	Mandate that performance-based contracting is required, monitored, and enforced to hold private providers accountable for improving child well-being, safety and permanence.
11.4 Quality Service Reviews	Quality Service Reviews that effectively examine practice are required and supported.
11.5 Independent ombudsman office or other independent advocate	Mandate oversight of individual treatment through an independent ombudsman office or other independent advocate.

Racial Equity Promotion

12

African American families were found to be investigated twice as often as Caucasians[302] despite the fact that there are no statistically significant differences in overall maltreatment rates between African American and Caucasian families[303] In fact, after controlling for income, unemployment and location (urban or rural), African American communities actually have lower rates of child maltreatment than Caucasian communities.[304] Yet, African American children were 36% more likely than Caucasian children to be placed into foster care.[305] The fact that children of color are not only over-represented[306] but also experience significantly worse outcomes than non-minority children[307] has led to a growing belief that lasting improvements in the child welfare system are not possible unless these inequities are eliminated.[308]

A recent General Accounting Office (GAO) report noted that child welfare administrators identified racial bias or cultural misunderstanding among decision makers as one of three factors potentially influencing racial disproportionality.[309] Many states are working to quantify, comprehend and address this potential bias, which is key to reducing the structural elements contributing to disproportionality. Some states, such as Texas, require child welfare workers to be trained in "Undoing Racism" to analyze the ways in which structural racism may affect their decisions.[310, 311]

In Michigan, as a result of overwhelming concerns about racial disparities, advocates worked with the legislature to require a task force report on racial disproportionality in child welfare and juvenile justice including recommendations for long term

improvements.[312] After securing consumer input and reviewing all available data, the Michigan Advisory Committee on the Overrepresentation of Children of Color in Child Welfare issued a report with 11 recommendations related to funding, policies, programs, and procedures, family engagement, resources, building support for reducing disparities, and accountability on the state and local level.[313]

The data collection components of the analysis included the use of the Quality Service Review (QSR) and Praxis Institutional Analysis. The QSR methodology was employed to examine practice and systems through a review of cases and the input of frontline practitioners, family members, and service providers involved in those cases. The Praxis Institutional Analysis process drew together administrators, workers, and child welfare experts to jointly examine the data and information to uncover how racial disparity comes about in practice, policies and the allocation of resources. This combination of tools resulted in a data collection process that involved case file review, interviews, focus groups, observations (hotline calls, investigations, family team meetings, court hearings) and review of policy documents, services and funding.

A standing committee at the state level is now required to submit an annual report to the legislature on the state's progress towards reducing disparities through a range of strategies resulting from the 10 recommendations. One important recommendation is the creation of local accountability groups to continue the review of data and evaluation of progress in each county.[314]

This process highlighted several essential elements to begin addressing racial disparities in the systems: legislature and advocate engagement; the creation of a broad-based task force; significant consumer input; substantial and systematic review of data; training of reviewers both on process and principles key to racial disparities; use of standardized tools for the collection of both qualitative and quantitative data; establishment of a plan with measurable benchmarks; and ongoing monitoring and oversight.

12.1 Data monitoring and annual reporting of racial disproportionality.

Despite a general understanding of disproportionality in child welfare, states and jurisdictions require an analysis of their own data to fully comprehend the issues in their systems: "Analysis of child welfare outcome data by race and ethnicity is virtually always one of the triggers for agencies to give increased priority to addressing racial disparities. For most jurisdictions, the data reveal such dramatic disparities that, once recognized, action to address the problem becomes urgent".[315]

Data is crucial to identifying the problem and developing effective strategies, but 18 states do not regularly collect data or use it to address disproportionality.[316]

To ascertain the causes and potential opportunities for change, the Casey/Center for the Study of Social Policy Alliance on Racial Equity (Casey/CSSP Alliance) developed a scorecard approach as a tool for decision making that uses data that jurisdictions may already collect to examine issues of racial equity. Woodbury County Iowa, identified as one of ten "Promising Practices" sites by the Casey/CSSP Alliance,[317] implemented a scorecard that reviews disproportionality by race for child placements in out-of-home care; disparity ratios for decision making stages by race/ethnicity and disparity ratios for out-of-home type by race.[318]

An analysis of decision points helps administrators and staff understand how and where inequities are occurring in the system. These decision points include child protective services investigations, substantiations, placements, terminations of parental rights and exits to permanency. As previously noted, African American children are more likely to be placed in foster care than non-minority children. Additionally, once African American children are removed from their homes, their lengths of stay in foster care average 9 months longer than those of White children. State child welfare directors reported again that bias or cultural misunderstanding, as well as distrust between child welfare decision makers and the families they serve, contribute to the removal of children from their homes and potentially prevents early reunification.[319]

The report developed by the Michigan Task Force described previously (see p.g. 126) detailed the need to examine decision points and documented statewide racial disparities in placement rates noting significant variations between counties.[320]

Policy Option: States can mandate data collection on outcomes by race and analysis of decision-making points and processes that contribute to racial disproportionality.

12.2 Benchmarks for reducing racial disproportionality.

In order to track improvements, measures must be developed that describe targeted outcomes and permit an objective assessment of performance. These benchmarks are predictors that the project is progressing as planned through a process that reviews qualitative and quantitative data.

Several states are attempting to develop reform plans through an open engagement of stakeholders and a review of the data, such as the Illinois African-American Family Commission that was established by law to monitor legislation, programs, policies and research that enhance the wellbeing of African-American families. The

commission is further charged with developing agency strategies and community-based services.[321] In Massachusetts a legislative oversight committee conducted a review of the child welfare system in 2006 that resulted in a report with wide-ranging recommendations. Among the immediate action steps was to require the agency to address disproportionality with a detailed plan to be reported back to the legislature.[322] The Michigan plan requires the state agency and the local child welfare offices to:

- Establish work groups to implement new policies and practices, and to develop the data, information-gathering and reporting tools needed to track the impact of race and ethnicity in the child welfare system and
- Use data to establish baselines, assess progress and determine customer satisfaction.[323]

Policy Option: States can mandate that child welfare systems (including public agencies, private contract agencies, and courts) reduce racial disproportionality using measurable, time-specific benchmarks to ensure accountability.

Policy Area 12: Racial Equity Promotion Summary of Policy Options

Policy Area	Policy Options
12.1 Data monitoring and annual reporting of racial disproportionality	Mandate data collection on outcomes by race and analysis of decision-making points and processes that contribute to racial disproportionality.
12.2 Benchmarks for reducing racial disproportionality	Mandate that child welfare systems (including public agencies, private contract agencies, and courts) reduce racial disproportionality using measurable, time-specific benchmarks to ensure accountability.

Problem-Solving Courts and Court Improvement Strategies

13 Court Systems

The goal of problem-solving courts in child welfare is to ensure parents have the necessary skills to provide a safe and stable home environment and, ultimately, ensure that their children become productive members of society

13.1 Judicial involvement in court improvement efforts.

Results for children and families involved in the child welfare system are improved when courts have effectively collaborated with agencies and multi-disciplinary teams. However, the child welfare agencies and the courts have not historically developed a strong working relationship. In fact, a report in 2000 by the Government Accounting Office found that this lack of a cooperative relationship between the courts and the child welfare system was one of two key problems identified in the family courts.[324] As a result, the Deficit Reduction Act of 2005 required collaboration between the courts, child welfare agencies, and tribes in order to access certain federal child welfare funding.[325]

One barrier to collaboration expressed by the judiciary is concern about ethical violations through activities that may be perceived as creating bias in future or current legal proceedings. To address this concern many states have adopted a model Judicial Canon: "Judges are, time permitting, encouraged to use their unique position

to contribute to the improvement of the law, the legal system, and the administration of justice... complete separation of a judge from extrajudicial activities is neither possible nor wise; a judge should not become isolated from the community in which the judge lives."[326]

The Pew Commission on Children in Foster Care recommended that courts demonstrate meaningful collaboration through active engagement in the development of policies and procedures, cross-training and information sharing. The Commission further recommended that these collaborative bodies "monitor and report on the extent to which child welfare programs and courts are responsive to the needs of the children in their joint care".[327]

Data collection and information sharing is critical to the progress of these reforms involving the courts and agencies. The Fostering Court Improvement initiative was launched in 2006 to enable courts and child welfare agencies to use existing Adoption and Foster Care Analysis and Reporting System (AFCARS) data to assess child outcomes from the time of removal to the time of discharge. The reports can be reviewed by county, judicial circuit, child welfare region or the entire state.[328]

Collaborations between child welfare and the courts have demonstrated important contributions to improving both systems. For example, in New York the Chief Judge and the Commissioner of the State Office of Children and Family Services worked through the Permanent Judicial Commission on Justice for Children to develop permanency legislation that provided for continuous calendaring of child protection cases, early investigation of non-custodial parents and other potential permanent placements for children, and continuing legal representation of children and parents. The Commission is comprised of judges and state and local agency officials, advocates, physicians, social workers, and legislators.[329]

Minnesota established the Children's Justice Initiative (CJI) that brought together the Supreme Court justice and the Department of Human Services commissioner to address statewide child welfare system reforms. CJI includes the lead judge from every county who act as liaison to local CJI in each of the state's 87 counties, where the local courts and county child welfare administrators work to develop system improvements.[330]

Policy Option: States can require judicial involvement in any state or local commissions or planning teams addressing child welfare improvements and services.

13.2 Court improvement models.

The families, children and child welfare agencies that come before family courts are frequently frustrated by delays, continuances, fragmented findings, and incomprehensible orders. Conversely, child outcomes and agency performance can both be significantly improved through court reforms. A leading example is Pima County, Arizona where a court-led initiative to improve educational outcomes for children in foster care resulted in system-wide changes.[331] Court improvements have become the focus of every state through federally funded programs and efforts by national organizations, such as the Pew Commission.

Twenty-five states report plans to improve the quality of child abuse and neglect court hearings, primarily through the establishment or support of model courts[332] such as Family Drug Court, One Court/ One Child, One Court/ One Family or Alternative Dispute Resolution processes such as mediation. A national cross-site evaluation of one these models, Family Drug Treatment Court (FTDC), found that parents entered substance abuse treatment more quickly, stayed in treatment longer, and completed more treatment episodes. Further, children of FTDC parents entered permanent placements more quickly and were more likely to be reunified with their parents, compared to children of non-FTDC participants.[333] The San Diego Dependency Court Recovery Project resulted in 81% of parents compliant with recovery plans and 3000 children returned home.[334]

Another important emerging practice involves expanding alternative dispute resolution (ADR) programs to include child welfare cases. Eighteen states developed or continued ADR programs, including trainings and establishing professional standards for mediators.[335] An evaluation of California's child welfare mediation program found that mediations result in full or partial agreement in at least 70 percent of cases.[336]

Policy Options: States can adopt court improvement models to maximize the enhance the effectiveness of the child welfare system.

13.3 Strategies to improve dependency court performance.

A national evaluation of court improvement programs reported on progress through 2005 and found that twenty-seven states identified activities implemented to improve the timeliness and efficiency of the court process in child abuse and neglect cases.[337]

Two types of docket management include block time and time certain docketing. In 'block time docketing' groups of hearings are assigned to specific blocks of time, whereas 'time certain docketing' establishes time averages for different types of cases that are used to schedule hearings. In both instances the purpose is to reduce the

waiting experienced by many families and agencies in family courts. However timeliness is a small part of the systemic change necessary to achieve an effective dependency court.

The ABA Center on Children and the Law, the National Center for State Courts, and the National Council of Juvenile and Family Court Judges jointly developed "Building a Better Court- Measuring and Improving Court Performance and Judicial Workload in Child Abuse and Neglect Cases" that promotes measures of timeliness, permanence, due process, and safety. These have become the nationally accepted standards for systemic improvement in the foster care court system.

Policy Options: States can promote improved court performance by adopting 1, 2, 3, or 4 of the following nationally accepted protocols:

- Accelerated timelines for appeals,
- Reduced judicial caseloads,
- Monitoring of adherence to timelines,
- Docket management including scheduling time-certain dependency hearings.

13.4 Collocation of services and/or assessments with courts.

Collocated services are thought to improve compliance by parents and increase communication among the providers and the courts. The services that are commonly ordered in family court matters include programs for child sexual abuse, substance abuse, mental health or domestic violence. The availability of these assessments or services near the court room both improve access and accelerate assessments resulting in more successful dependency cases.

Maryland has established Family Services Divisions within the courts which provide or contract for an array of resources: custody/visitation mediation; dependency mediation; custody evaluations; home studies; mental health/psychological evaluations; substance abuse assessments; co-parenting education; psycho-educational programs for children; individual, family and group therapy; anger management courses; substance abuse treatment; domestic violence planning; visitation centers (supervised visitation and monitored exchange); legal assistance projects for unrepresented litigants; and domestic violence programs.

Policy Options: States can promote improved access by adopting one of the following approaches to co-location (listed in increasing order of effectiveness):

- Assessments are collocated with courts
- Services are collocated with courts
- Services and assessments are collocated with courts

13.5 Required notice of, and participation in, court hearings.

The Adoption and Safe Families Act (ASFA) requires that foster parents, pre-adoptive parents and relatives providing care for a foster child must be provided with notice of, and an opportunity to be heard in, any review or permanency plan hearing. In 2005, twenty-seven states worked to improve the notification and treatment of parties, predominantly through developing resources to explain the child welfare system and court proceedings to families and to assist them in accessing services.[338] However, for many of the individuals who may be parties in a dependency case, explaining the system is a small first step towards ensuring full participation in cases that have a profound impact on their lives. For instance, participation of incarcerated parents in matters involving their children requires both notice and the facilitation of their appearance through either transportation to hearings or closed circuit or teleconference hearings. Grandparents are frequently acting as substitute caregivers, or may be willing to provide care, but are rarely notified of hearings related to their grandchildren. At a minimum, parents and grandparents should be actively engaged in child welfare proceedings.

Finally, many states do not require notice be provided to the children themselves who are the subjects of the proceedings. Under Connecticut law, children are entitled to be present at all court hearings and any objection to their presence must establish good cause for their exclusion.[339] Children in Louisiana are entitled to direct notice and to be present at all court hearings. Also, each child has a right to continued representation by counsel at each stage of the proceedings.[340]

Policy Options: States can require courts to provide notice of, and participation in, hearings for one of the following subsets of interested parties:

- Parents, children, grand parents and substitute caregivers
- Parents, children and grandparents
- Parents and children
- Parents

13.6 Training for attorneys, court staff, and judicial officers.

Child development, community resources, special family issues, the effects of trauma and the needs of children based upon their sexual orientation are all topics not generally understood by the legal community. Yet decisions are made every day that rely upon these and other matters distinctive to family court cases. In addition, many judges and attorneys are not equipped with an understanding of the unique state and federal laws governing child welfare proceedings. For example, a 2005 survey

of juvenile court judges, attorneys representing children, parents and agencies, and child welfare staff highlighted the lack of shared knowledge regarding the application of ASFA timelines to child welfare cases involving incarcerated parents.[341]

As a result of the need for specialized training, the California Center for Families, Children, and the Courts staff worked with the Legal Services for Children of San Francisco to develop model standards for treatment of Lesbian /Gay/ Bisexual/ Transgender/ Questioning (LGBTQ) youth. In Iowa, Juvenile Court Judges themselves requested training on the co-occurrence of child abuse and domestic abuse.[342] The New York State Permanent Judicial Commission on Justice for Children developed "Babies Can't Wait", a project that involves training on infant health and development for both the court and child welfare systems. They also developed a judge's bench card that provides critical information on the developmental and medical needs of infants.[343]

The Fostering Connections legislation opens up an important funding stream for training for court personnel. H.R. 6893 expands the availability of federal Title IV-E training dollars to cover training for court personnel, attorneys, guardian ad litems, and court appointed special advocates.[344]

Policy Options: States can require regularly scheduled judicial training on issues specific to dependency cases, including: dependency proceedings; child development, including the effect of poverty, family stress, and trauma; resources and supports necessary for effective parenting; issues and needs of LGBTQ youth; and resources, services and supports available within the community and public agencies for the following positions (listed in increasing order of effectiveness):

- Court staff
- Attorneys and Judges
- Judges, attorneys, court staff and social workers

Policy Area 13: Problem-Solving Courts and Court Improvement Strategies Summary of Policy Options

Policy Area	Policy Options
13.1 Judicial involvement in court improvement efforts	Require judicial involvement in any state or local commissions or planning teams addressing child welfare improvements and services.
13.2 Court improvement models	Adopt court improvement models to maximize the enhance the effectiveness of the child welfare system.
13.3 Strategies to improve dependency court performance	Promote improved court performance by adopting 1, 2, 3, or 4 of the following nationally accepted protocols: • Accelerated timelines for appeals, • Reduced judicial caseloads, • Monitoring of adherence to timelines, • Docket management including scheduling time-certain dependency hearings.
13.4 Collocation of services and/or assessments with courts	Promote improved access by adopting one of the following approaches to co-location (listed in increasing order of effectiveness): • Assessments are collocated with courts • Services are collocated with courts • Services and assessments are collocated with courts
13.5 Required notice of, and participation in, court hearings	Require courts to provide notice of, and participation in, hearings for one of the following subsets of interested parties: • Parents, children, grand parents and substitute caregivers • Parents, children and grandparents • Parents and children • Parents
13.6 Training for attorneys, court staff, and judicial officers	Require regularly scheduled judicial training on issues specific to dependency cases, including: dependency proceedings; child development, including the effect of poverty, family stress, and trauma; resources and supports necessary for effective parenting; issues and needs of LGBTQ youth; and resources, services and supports available within the community and public agencies for the following positions (listed in increasing order of effectiveness): • Court staff • Attorneys and Judges • Judges, attorneys, court staff and social workers

Timely and Qualified Legal Representation

14 14.1 Appointment and involvement of legal representation for parents and children.

In spite of the trauma to child development that results from separation from parents and the enormous implications for a child's future, only 36 states and the District of Columbia require that a lawyer be appointed to a child in dependency and foster care proceedings,[345] more than forty years after the Supreme Court established a child's right to counsel in delinquency cases.[346] While there is a federal right in delinquency court, there is no corresponding right in dependency court. As a result, the system of representation of children and parents in dependency cases is fragmented and uneven. Legal representation is the only avenue to ensure client involvement in dependency matters which go to the core of families. The best example of mandated representation is Mississippi which requires that all parties are represented by counsel at all stages of dependency proceedings.[347] This ensures that all parents and children are provided an opportunity to engage in the proceedings and be heard in matters fundamental to families. Ideally the mandate for continuous representation would be coupled with a strong legal services program such as the Brooklyn-based Center for Family Representation. The Center has created the Community Advocacy Team which consists of an attorney and a social worker that begin work with the client before a court petition is filed and continuously throughout the life of the case.[348] The attorney/social worker team provides an interdisciplinary approach that can result in better service plans and case outcomes.

Policy Option: States can require that representation for parents and children is appointed and actively involved prior to the first court hearing and continuously throughout the proceedings, including appeals through automatic appointments prior to the first hearing, and ongoing throughout case including appeal.

14.2 Effectiveness of legal representation for parents and children.

Due to the immense responsibilities associated with the work of attorneys in child welfare proceedings, thirty-five states are implementing activities to improve the representation of parties in child abuse and neglect cases. However these improvements are primarily through targeted training and resource development for attorneys, Guardians ad litem (GALs), and/or Court-Appointed Special Advocates (CASAs).[349] For instance, Connecticut requires four "mentoring sessions" for new attorneys. Each session emphasizes a specific topic area and case examples are used to assist the attorneys in key skill development. California requires twenty-eight hours of education for attorneys comprised of eight hours of initial training and 20 hours of continuing training within the attorney's first year of dependency practice.[350] The Fostering Connections Act expands funding for these efforts by allowing Title IV-E training funds to be used to train attorneys, guardian ad litems, and court appointed special advocates.

While training and mentoring are important efforts, they must be supported by an infrastructure that allows attorneys to access all the necessary tools to effectively represent their clients. The National Association of Children's Counsel (NACC) noted that Child Welfare Attorneys "must possess expertise in state and federal substantive and procedural law, trial advocacy and dispute resolution, collateral proceedings, community resources and services, family dynamics, and child maltreatment and development. … The delivery of child welfare legal services requires a practice infrastructure, which provides the attorney with the necessary time, compensation, and resources…— in other words, a dedicated child welfare law office".[351] NACC recommends, among other things, case load standards, training, certification and a multi-disciplinary practice. The Support Center for Child Advocates in Philadelphia is a model of NACC's standards for a child welfare law office. The Center trains and supervises both staff and volunteer attorneys who are paired with staff social workers. The team then works together to conduct home visits and attend administrative and social service meetings and represent the client at all court proceedings.[352]

Policy Option: States can require effective representation of mothers, fathers, children and substitute caregivers by adopting 1, 2 or 3 of the following:

- Trained attorneys with manageable caseloads
- Through the expansion or creation of staff attorney programs that include supervision, training and mentoring
- Attorney/social worker teams

14.3 Standards for legal representation for children, parents, and agencies.

Despite the complexities of child development, child welfare laws and issues related to vulnerable families, a recent survey revealed that 50% of court improvement specialists reported that that the duties of child welfare attorneys are not specified by either rule or statute,[353] resulting in wide variations in quality both within a state and across the states. This lack of uniformity has led to significant efforts to establish standards at the state and the national level. The ABA has issued standards specific to the representation of parents,[354] children[355] and child welfare agencies.[356] Five states participate in the Certified Child Welfare Law Specialist program for attorneys who represent children, parents and agencies in child abuse, neglect and dependency cases, which requires:

- No less than 20 percent of practice in child welfare law for the three (3) years;
- Continuing legal education credit in child welfare law;
- Peer reviews, including one judge;
- Writing sample; and
- Child welfare law exam.[357]

The representation of children has received specific attention. On the national level, the National Conference of Commissioners on Uniform State Laws[358] issued a model act for the representation of children that addresses mandatory appointments, duration of appointment, qualifications, and duties such as active engagement of client, investigation of case facts, involvement in case development and participation in case staffing or meetings.

Two examples of state approaches, Alabama and Wisconsin, demonstrate the use of training and certification to ensure quality representation of children. Alabama requires certification of GALs through initial training and bi-monthly continuing legal education credit covering updates of juvenile dependency, termination of parental rights law and other relevant topics. Wisconsin has adopted Court Rule

35, "Eligibility for Appointment as Guardian ad litem for a Minor", which requires a minimum amount of approved training for appointment eligibility. The training topics include: assessing parenting ability; family law ethics; foster youth transitions to adulthood; forensic interviewing; child sexual abuse; case law update; child psychopharmacology; methamphetamine effects on the brain and consequences for parenting.[359]

Policy Options: States can require that representation for children, parents and agencies is required to meet one of the following minimum standards (listed in order of rigor):

- ABA standards in court rule or law
- Certification

Policy Area 14: Timely and Qualified Legal Representation Summary of Policy Options

Policy Area	Policy Options
14.1 Appointment and involvement of legal representation for parents and children	Require that representation for parents and children is appointed and actively involved prior to the first court hearing and continuously throughout the proceedings, including appeals through automatic appointments prior to the first hearing, and ongoing throughout case including appeal.
14.2 Effectiveness of legal representation for parents and children	Require effective representation of mothers, fathers, children and substitute caregivers by adopting 1, 2 or 3 of the following: Trained attorneys with manageable caseloads Through the expansion or creation of staff attorney programs that include supervision, training and mentoring Attorney/social worker teams
14.3 Standards for legal representation for children, parents, and agencies	Require that representation for children, parents and agencies is required to meet one of the following minimum standards (listed in order of rigor): ABA standards in court rule or law Certification

Interagency Collaboration

15 Agency Effectiveness

Interagency collaborations enable agencies to develop creative cross-agency strategies to shared problems or populations. Many child welfare collaborations involve another single agency, such as domestic violence or substance abuse agencies. However, to broadly address the external influences on child welfare's goals of safety, permanency and well-being of children and families a larger collaborative effort is needed, given that relevant partners to child welfare's outcomes include multiple state agencies. State-level coordinating structures may be "the cheaper, faster and better alternative for affecting cross-system, cross-outcome change".[360] Such as Pennsylvania's Cabinet on Children and Families which was established to coordinate and streamline government services for children and families. The cabinet is made up of the secretaries of Public Welfare, Education, Health, and Labor and Industry; the Secretary of the Budget; the Insurance Commissioner; the directors of the Office of Health Care Reform and the Governor's Office of Policy; the Governor's Chief of Staff; and the chairpersons of the Juvenile Court Judges' Commission and the Commission on Crime and Delinquency. Twenty-one states have established Children's Cabinets or Councils for the purpose of improving services and outcomes for children and families. These partnerships allow agency leaders to:

- Plan for improvements;
- Convene key stakeholders;
- Establish a vision;

- Provide leadership;
- Identify and coordinate financial resources;
- Provide support for training and technical assistance;
- Identify existing budget assets and gaps;
- Identify and interpret resources uses, restrictions and reporting requirements;
- Ensure accountability and outcomes; and
- Develop interagency agreements.

Interagency collaborations, whether involving two partners or multiple agencies, require a set of "tools" to ensure their ability to meet a shared mandate. The tools necessary are flexible funding, common outcomes measures, the ability to share information, interagency agreements that specify responsibilities, and a coordinated process for service delivery.

15.1 Funding flexibility.

Children, and their families, are not one dimensional and yet funding for services is largely focused on a single problem or issue, which contributes to the fragmented approach to serving families. To improve service delivery agencies are encouraged, and in some instances mandated, to work cooperatively across systems which requires constructing methods of funding to support services either at the micro level (e.g. a child's service plan) or at the macro level (across agencies). Over the years various financing strategies have been developed, but to date the research is not available that evaluates the effects of funding flexibility separate from the outcomes of the overall initiative.[361] As a result, the financing approaches tend to be guided by the functions of the initiative and fall into four broad categories: decategorized, redirected, braided, or blended/pooled. Decategorized is defined as removing the restrictions on the use of the dollars, such as eligibility requirements, targeted populations, or restricted services. Blended funding is taking multiple funding streams and commingling them into a single source or pool (also known as pooled funding). Braided funding retains the categorical restrictions and is separately administered but allows multiple agency funding streams to be directed in a coordinated fashion towards the same initiative or objective. Redirected funds takes money targeted at one project or program and shifts it to a new target, this is frequently used for moving investments from 'deep-end' services to early intervention programs. Each of these financing strategies is designed to support a full range of services not covered by strictly categorical funding sources and permit interagency collaborations the opportunity to sufficiently resource their defined goals.

In Ohio the "Kids in Different Systems" project (KIDS) is financed through pooled funding from five agencies, child welfare; education; juvenile justice; the Alcohol, Drug Addiction and Mental Health Board; and the Mental Retardation/Developmental Disabilities Board. KIDS provides community- based services for dual custody children at risk of out-of-home placement or those stepping down from a restrictive setting. The Monroe County Health Department in Rochester, New York, decategorized seven funding streams into one Child and Family Health Grant to support the delivery of integrated health services.[362]

While Iowa is commonly known for decategorizing funding, the initiative also contained an incentive component. In 1987 the Iowa General Assembly directed the Department of Human Services to decategorize funding into a single locally controlled fund with the goal of reducing the child welfare system's reliance upon institutional and out-of-home care. As result, between 1994 and 1998 there was a 21 percent decline in out-of-state placements with $16.5 million savings retained by counties and reinvested in preventive services.[363]

An example of the use of blended funds with an incentive structure is Maryland's Local Management Boards (LMBs). The initial work of LMBs focused on family preservation services for children at-risk of placement and community-based services for youth returning from out-of-state placements. Funds from the state child serving agencies were pooled which could be used flexibly by the LMBs on any service the child and family needed. The LMBs were authorized to keep up to 75% of any savings (the difference between the granted amount and the actual cost of services). The remaining 25% of the savings was retained by the state. Through this incentivized process LMBs significantly reduced the number of children placed out of state.[364]

Policy Options: States can promote funding flexibility across programs, agencies, and categorical funding streams through one of the following mechanisms (listed in order of increasing effectiveness):

- Incentives and encouragement only
- Decategorization and pooling only
- Both decategorizing/pooling and incentives

15.2 Common result measures.

To determine whether agencies and organizations have met their responsibilities to families, a set of common measures is necessary. Many jurisdictions have adopted a results accountability system because it offers an opportunity to:

- Engage stakeholders and program providers in building broadly shared visions of what goals are important and what strategies are required to achieve them.

- Think creatively about solutions while ensuring that interventions are timely and relevant.
- Move from categorical program approaches to more holistic ones.
- Examine how different interventions can be integrated to achieve mutually shared goals.
- Collect data and monitor progress systematically, to identify and critically examine successes and failures, and to use this information to improve operations, services, and outcomes.
- Demonstrate results and build confidence in public institutions.[365]

To develop shared outcomes agencies, organizations and collaboratives start by asking:

- What conditions of well being (results) do we want for children, adults, families and communities, stated in plain language?
- How could we recognize these conditions in measurable terms? (indicators)
- What are our baselines? Where have we been and where are we headed on the indicators?
- What is the story behind the baselines? Why do the indicator baselines look the way they do? What are the causes?
- Who are the potential partners who have a role to play in doing better?
- What works? What do we think it will take to do better?
- What do we propose to actually do (action plan and budget)?[366]

Since 1996, Maryland has used this results-based framework to advance the well-being of children and families. Eight Results for Child Well-Being were established that included 25 indicators to measure the current status of children and families and how trends emerge over time. The results and indicators were developed through a statewide process that engaged all stakeholders. This has allowed the State, in partnership with local jurisdictions, to evaluate the challenges that children face, select priority areas, set goals for improving child and family well-being, and monitor the impact of resources, such as services, programs and initiatives, both on the state and the local level. Each local jurisdiction, through the network of Local Management Boards (LMBs), is required to examine the same results and indicators on the jurisdictional level to establish local priorities. For example, one state result is "Babies Born Healthy", with the indicators of infant mortality, low birth weight, and births to adolescents, which can be measured on the state level and disaggregated to the local level. Services that are then funded by Maryland's Children's Cabinet under this result area would have program measures established jointly by the state and the local jurisdiction to determine performance through process (e.g. number of families served or number of home visits), outputs (e.g. percentage of mothers that were enrolled pre-natally) and program level outcomes (e.g. rate of low birth weight for clients). In 2000 Maryland elected to focus on "Children Enter School Ready to

Learn" and has seen the statewide school readiness scores increase from 49% to 67% in 6 years.[367]

Policy Options: States can require that common measures are used across agencies, programs, and with local jurisdictions to publicly monitor child and family outcomes by adopting one of the following standards for commonality (listed in order of increasing effectiveness):

- Across agencies
- Across agencies and with local jurisdictions

15.3 Protocols and mechanisms to share case information.

Children and families are often in contact with more than one agency which necessitates the sharing of information between agencies to coordinate the delivery of services. Although the need to share information has been clear, there have been few strategies to facilitate this exchange. Wisconsin conducted a study to identify appropriate strategies which included a survey to determine the type and purpose of the information needed by various agency partners. Respondents from over 95% of the counties indicated that they needed information to "provide appropriate services, make appropriate decisions, assure public safety, validate information, improve continuity of care, assure accountability and improve competency development."[368] In order to accomplish these goals many states have relied upon interagency agreements[369] among the partners of a large collaborative or between two specific agencies. For example the Seattle Foster Care and Education Consortium is developing a system of shared databases between the Division of Children and Family Services and the Seattle Public Schools in order to identify youth in out-of-home care, trigger a timely records transfer each time a youth moves to a new school, and report on education outcomes such as test scores, attendance, GPA, and graduation status. These goals have been outlined in a Memorandum of Understanding signed by both agencies.[370]

However, information sharing has a number of barriers including technology incompatibility and confidentiality laws that agencies have been forced to overcome in an ad hoc fashion. Until recently there has been little guidance to assist the agencies on how to develop policies, protocols or agreements. In 2006 the federal Office of Juvenile Justice and Delinquency Prevention (OJJDP), U.S. Department of Health and Human Services (HHS), U.S. Department of Education (DOE) and the Substance Abuse and Mental Health Services Administration (SAMHSA) collectively developed "Guidelines for Juvenile Information Sharing" that lay out policy considerations, legal issues, process objectives, procedures and recommendations for implementation to guide the states in developing information sharing solutions.[371]

Policy Options: States can require protocols and mechanisms for sharing case information across programs, agencies, and with local jurisdictions by adopting one of the following standards for commonality (listed in order of increasing effectiveness):

- Across agencies
- Across agencies and with local jurisdictions

15.4 Integrated or coordinated case management and service delivery.

Parents are frequently forced to act as a coordinator of services in most systems where agencies are separately located, often with a significant distance between them. These divisions lead to conflicting plans, services and timelines. Integrated or coordinated case management involves professionals working together in the same location blending services into a cohesive case plan. Case coordination is the cornerstone of the Wraparound process that has demonstrated remarkable outcomes with a wide variety of populations. A study of Wraparound in Nevada, which serves child welfare involved children and families, resulted in less restrictive environments, increased placement with family members and improvements in school attendance, school disciplinary actions, and grade point averages.[372]

Preliminary research of Child Advocacy Centers, which coordinate the child sexual abuse case management of child protection, law enforcement and mental health agencies, indicate fewer foster care placements for abused children, a reduction in the number of child abuse interviews for the victim (reducing re-trauma), improved collaboration between multiple government agencies and increased confessions, prosecution rates, and convictions for perpetrators.[373]

The Community Resources for Families program is a partnership between the Idaho Department of Health and Welfare and school districts that locates social workers in elementary schools. Social workers and school personnel jointly coordinate case management and referrals to community-based services, which was demonstrated to be effective in providing for the safety and well-being of children at risk of child abuse and neglect.[374] The Prince Hall Family Support Center in St. Louis, Missouri, established under the Department of Social Services, is located in a former hospital and staffed by 14 private agencies and five state agencies — Child Support Enforcement, Family Services, Office of Youth Development, Family Court and Division of Aging. The center has developed a uniform intake system, case management process and referral system.[375]

Team staffing approaches and out-stationing of staff can also allow both child welfare and domestic violence treatment skills and practices to keep families safe. Michigan has provided funds for some domestic violence shelters to hire their own family preservation workers. These workers are able to work with families at risk of homelessness or living in abusive environments to reduce the risks and increase the mother's capacity to safely care for the child. At the same time, child abuse or neglect must be referred to the child welfare agency.

The Massachusetts Department of Social Services (DSS) developed the position of domestic violence advocate to train child welfare staff to identify domestic violence, explore safe interventions, and find appropriate resources in the community. Over the years DSS developed a Domestic Violence Program unit based in the central office and staffed by domestic violence advocates or "specialists" and supervisors. DSS developed an agency-wide domestic violence protocol, but maintains that the specialists are key to its effectiveness.[1]

Resistance to integrated case management is largely based upon concerns about categorical funding, federal laws and program regulations. A recent review of potential barriers to service integration that reviewed federal statutes, regulations, and policy guidance on programs and funding revealed there are no major obstacles to cross-program integration. The authors concluded that federal guidelines provide significant support for combining services to provide more comprehensive, integrated services to families.[376]

Policy Options: States can require integrated or coordinated case management and service delivery across agencies and with local jurisdictions by adopting one of the following standards for commonality (listed in order of increasing effectiveness):

- Across agencies
- Across agencies and with local jurisdictions
- Across agencies and with local jurisdictions that include experts to provide consultation and training

Policy Area 15: Interagency Collaboration Summary of Policy Options

Policy Area	Policy Options
15.1 Funding flexibility	Promote funding flexibility across programs, agencies, and categorical funding streams through one of the following mechanisms (listed in order of increasing effectiveness): • Incentives and encouragement only • Decategorization and pooling only • Both decategorizing/pooling and incentives
15.2 Common result measures	Require that common measures are used across agencies, programs, and with local jurisdictions to publicly monitor child and family outcomes by adopting one of the following standards for commonality (listed in order of increasing effectiveness): • Across agencies • Across agencies and with local jurisdictions
15.3 Protocols and mechanisms to share case information	Require protocols and mechanisms for sharing case information across programs, agencies, and with local jurisdictions by adopting one of the following standards for commonality (listed in order of increasing effectiveness): • Across agencies • Across agencies and with local jurisdictions
15.4 Integrated or coordinated case management and service delivery	Require integrated or coordinated case management and service delivery across agencies and with local jurisdictions by adopting one of the following standards for commonality (listed in order of increasing effectiveness): • Across agencies • Across agencies and with local jurisdictions • Across agencies and with local jurisdictions that include experts to provide consultation and training

Skilled and Stable Workforce

16

A stable and highly skilled workforce is required to ensure the safety, permanence and well-being of children served through child welfare programs. Child welfare staff work with extremely vulnerable children and overwhelmed families, and they are critical participants in some of the most serious decisions possible in the lives of children and their parents. These responsibilities present significant stresses on the child welfare workforce, and in turn, the performance of these workers has enormous consequences for the lives of individual children and families and for the implementation of child welfare policies.

Annual turnover of public child welfare staff is estimated to be from 20 to 40 percent, and the average tenure for child welfare workers is less than two years.[377] Although turnover varies among staff positions, there is little analysis of the differences. Private agencies provide a range of services that varies widely among states (80 percent of child welfare services in Illinois, for example),[378] and these agencies are likely to experience even higher turnover than the public sector.

According to surveys of child welfare administrators, agency reports, and academic studies, problems associated with high staff turnover are complex, multidimensional and widespread. The most severe problems identified in a 2004 by the American Public Human Services Association (APHSA) were:

- Workloads and caseloads that are too high and/or too demanding;
- After-hours and unpredictable work that interferes with personal and family life;

- Too much time spent on travel, transport, paperwork and other activities that take away from time available to work directly with families and children;
- Insufficient service resources for families and children;
- Workers not feeling valued by the agency;
- Problems with quality of supervision;
- Insufficient opportunities for promotion and career advancement;
- Low salaries.[379]

High turnover is both a result of problems in the workplace and a problem in itself. It creates a cycle of recruitment, hiring, and training new staff that undermines agencies' performance and outcomes for children and families. The effect ripples throughout the workforce as remaining staff must fill the vacuum left by departing colleagues. In addition to higher caseloads for existing staff during recruitment and hiring of new workers, the large number of authorized workers in training at any given time (up to 30 percent in some agencies) limits staff available to carry cases.

Human resources experts estimate that the financial costs of replacing a single employee are about one-third to one-half of the exiting worker's annual salary.[380]

A growing body of evidence documents the negative impact of child welfare workforce problems on children. A study of turnover among Milwaukee County private agency child welfare case management staff found that the more caseworker changes a child experienced, the lower his/her chances of achieving a permanent family.[381] Another study of 12 California counties revealed that county agencies with the highest turnover rates had about twice as many recurrences of child abuse or neglect.[382] The Government Accountability Office (GAO) reports that worker turnover also can disrupt service continuity, especially when departing staff leave behind poor or insufficient information in case files. Along with large caseloads, worker turnover hinders achievement of key safety and permanency goals by delaying investigations and limiting worker visits.[383]

The first 27 state Child and Family Services Reviews (CFSRs) conducted by the federal government found a direct relationship between the consistency and quality of caseworker visits with children and families and the achievement of case outcomes evaluated in the reviews. High caseloads, training deficiencies and staffing shortages affected the achievement of at least one performance measure for every state and an average of nine measures per state. Reviewers also cited staff turnover and vacancies as affecting workers' responsiveness to children and families and decreasing their ability to help children achieve permanency.[384]

States have implemented a variety of initiatives aimed at improving the stability and performance of the child welfare workforce, but very few have been fully evaluated. It is clear from agency reports and workforce data that a comprehensive approach with strategies directly focused on workforce improvement is required.

16.1 Monitoring and use of data to strengthen the workforce.

Few child welfare agencies have detailed understanding of their child welfare workforce beyond the number and distribution of staff in specific job classifications; whether staff members meet basic requirements for hiring, retention, and promotion; and their salary levels. To develop and maintain a picture of the workforce, a range of additional information needs to be collected and monitored for various positions, units and even individual supervisor teams. Workforce data are essential for development of state-tailored strategies that will make a positive difference in retention and performance and respond to workers' needs and concerns.

Data that contribute to better understanding of the workforce and planning of strategies for improvement may include:

- turnover data;
- number, position, and location of staff eligible for retirement;
- caseloads, workload analyses, and studies of how staff spend their time; and
- race, ethnicity, and languages of staff.

Other types of information that are essential to track are worker satisfaction and staff concerns, views and suggestions. Meaningful exit interviews, staff surveys, and routine two-way communication between management and staff help to monitor frontline challenges, identify strategies for improvement, and effectively implement workforce improvements. Feedback to staff completes a cycle that informs them about the response to their concerns and contributes to a continuous workforce improvement process.

In 2003, Texas legislation required the Department of Protective and Regulatory Services (now known as the Department of Family and Protective Services) to develop a human resources management plan designed to improve employee morale and retention.[385]

As part of a child welfare workforce planning initiative, the Arizona Department of Economic Security Division of Children, Youth and Families is developing a workforce data scorecard. A variety of data about staff are being collected by human resources partners, routinely updated and shared with child welfare district managers, supervisors and other staff, as well as central office administrators. In addition, exit interviews and staff satisfaction surveys are being streamlined and improved. The data directly inform a workforce planning model that features a partnership between child welfare and human resources staff.

Policy Options: States can promote the strength of the workforce by adopting one of the following policies (listed in order of increasing effectiveness):

- Exit surveys, periodic staff surveys and other agency communication strategies are conducted to monitor challenges, views and recommendations of staff.
- Data regarding the status, characteristics, and views of the workforce are systematically and routinely monitored.
- Quantitative and qualitative data are used to develop plans for strengthening the workforce.

16.2 Caseload limits for frontline workers.

A range of federal and state studies shows a connection between caseloads and workloads, service effectiveness and caseworker retention. Findings of the federal Child and Family Services Reviews (CFSRs) demonstrated more positive safety and permanency outcomes when child welfare workers have more contact with the children and families they serve. GAO analysis of federal CFSRs corroborated caseworker accounts that large caseloads and worker turnover delay the timeliness of investigations and limit the frequency of worker visits with children. Caseworkers reported that staffing shortages and high caseloads have had detrimental effects on their abilities to make well-supported and timely decisions regarding children's safety and force them to focus only on the most serious circumstances of abuse and neglect.[386] Child welfare officials in 35 states interviewed by the GAO reported having trouble recruiting and retaining caseworkers because many caseworkers are overwhelmed by large caseloads.[387]

Among state studies, a New Hampshire audit of the foster care system found that excessive workloads hindered the child welfare agency's ability to provide quality services and recommended that the division develop and adhere to workload and caseload standards. The Florida Senate Committee on Children and Families conducted a two year study of turnover among child protection investigators and supervisors and concluded that the primary cause was excessive caseloads and workloads.[388]

Child welfare administrators report that workload is an ongoing concern. Eighty-one percent of 2005 APHSA survey respondents viewed excessive workloads as a highly problematic retention issue. They also ranked it as a main factor impacting recruitment, since salaries are not viewed as compensatory for the highly perceived workload. To compound the pressure, high turnover and staffing shortages further increase workload of remaining staff, resulting in delayed maltreatment investigations, fewer worker visits with children and their families, limited opportunities for relationship-building, and

hastened decision-making that affect systems' abilities to ensure the safety and placement stability of children served.[389]

The average caseload for child welfare workers has been reported at between 24 and 31 children, with a range in caseloads from 10 to 100 children per worker.[390] California managers interviewed by the GAO stated that caseworkers often handle twice the number of cases recommended. At the same time, children and families that workers serve face increasingly complex situations often including poverty, drug or alcohol abuse, mental illness, and other difficult problems.

The Child Welfare League of America suggests a caseload ratio of 12 to 15 children per caseworker, depending on the level of service required for each child. Factors to be considered in determining appropriate caseload size include the complexity of children's and families' needs, the worker's level of competency, the functions assigned and the time required for case-related activities, and the geographic area served.[391]

Legislatures are frequently called upon to appropriate funds in order to lower caseloads. In 2004 alone, Alaska, Nebraska, North Carolina and West Virginia appropriated funds for new positions to lower caseloads. As part of comprehensive child welfare legislation enacted in 2003, Arizona lawmakers appropriated almost $2 million to meet national staffing standards for public child welfare caseloads. In 2005, legislators again appropriated an increase of $8.7 million for additional positions and required the Department of Economic Security to submit specific child welfare caseload standards.[392]

In 2005, new caseload caps were mandated to take effect in Indiana in 2008:

- For caseworkers assigned only initial assessments, including investigations, 12 active cases per month per caseworker;
- For caseworkers assigned only ongoing cases, 17 active children per caseworker; and
- For caseworkers assigned a combination of initial assessments (including investigations) and ongoing cases, four investigations and 10 active ongoing cases per caseworker.[393]

Also in 2005, the Maryland child welfare agency was required to meet Child Welfare League of America caseload standards and funding was appropriated for that purpose.[394]

Policy Options: States can adopt and fund the implementation of one of the following policies (listed in increasing order of effectiveness):

- Caseloads do not exceed other standards set by the state.
- Caseloads do not exceed Child Welfare League of America standards.

16.3 Appropriate supervisor to staff ratios.

By investing in strong supervision and support for caseworkers, policymakers can help improve the quality of case planning, decisions, and services for children and families while alleviating the cycle of frontline staff turnover. Skilled supervisors who are available and accessible also contribute to the safety of workers serving children and families in crisis.[395] Numerous research studies, staff surveys and agency performance reviews indicate that supervision has an enormous impact on workers and the quality of their work.[396] The majority of states with the most improved data indicators in their CFSR Performance Improvement Plans (PIPs) included strengthening supervision.[397]

The GAO found that supervisory support either motivated caseworkers to stay despite the stress and frustration of the job or that lack of supervisory support was a critical factor in their decision to leave.[398] In the 2004 APHSA survey, state child welfare agency administrators ranked strong supervision as the most important organizational and personal factor contributing to staff retention and among the top three actions and initiatives that child welfare agencies must take to retain caseworkers.[399]

The role of supervisors is to provide administrative, educational, and supervisory support to staff. Supervisors who work with the employee each day enhance critical thinking, model evidence-based practice, and help establish a culture of excellence. Key functions include:

- Assigning cases,
- Monitoring caseworkers' progress in achieving desired outcomes,
- Providing feedback, direction and guidance to help workers develop their skills,
- Recognizing and responding to the needs and concerns of caseworkers, such as emotional, safety and workplace issues;
- Analyzing and addressing practice problems and barriers,
- Reviewing and making decisions about cases.

Because they provide a bridge between the frontlines and management, supervisors have an important responsibility to enhance two-way communication and to inform policy decisions with lessons from frontline staff. They also have a critical role in establishing agency credibility and building organizational and community expertise.

Adequate supervisor to staff ratios help to ensure that workers have the level of supervision and support they need and allow supervisors to provide consultation and coaching for frontline staff. The GAO found that lack of adequate supervisors and supervisor workloads interfere with supervisors' ability to provide the necessary oversight, and to impact staff effectiveness; thereby contributing to poor staff morale. Often, to relieve high caseloads for workers, supervisors carry a caseload of their own — a practice that further inhibits their ability to coach and supervise staff.

Standards developed by the Child Welfare League of America state that supervisor to child welfare caseworker ratios should not exceed one to five at any given time. Standards of the Council on Accreditation are generally one to eight. However, the appropriate ratio depends on the qualifications of the caseworker and the supervisor, the complexity and intensity of activities and/or services, and other agency responsibilities.

Class action lawsuits in DC, GA, and NJ have led to the development of caseload standards of one supervisor to six caseload-carrying social workers including case aides, or five caseworkers at any given time. A collective bargaining agreement between the Commonwealth of Massachusetts and an alliance of human services unions in 2001 specified a supervisor to caseworker ratio of one to five.[400] Like most states, Iowa has struggled with having an adequate number of trained supervisors. However, legislative funding has allowed the agency to recruit, train and retain additional supervisors.[401]

Policy Options: States can mandate that supervisor to staff ratios do not exceed nationally acceptable standards.

16.4 Supervisor competencies and support.

Not only are adequate numbers of supervisors necessary for child welfare system performance, supervisors must have appropriate skills and access to the supports they need. Due to high staff turnover, some states report that caseworkers with only three years of experience are often promoted to supervisory positions, and newly promoted supervisors report that they feel poorly prepared for the job.

At the same time, training for supervisors results in increased worker satisfaction, reduced preventable turnover and improved practice and outcomes.[402] Programs that improve supervision through leadership development and specific mentoring relationships appear to aid in staff decision making and reduce staff stress related to effectively handling their cases.[403] With federal grant funding, the Southern Regional Quality Improvement Center (SRQIC) for Child Protection focused a 5-year program

of research and demonstration projects in four states on identifying innovations in supervisor practice that would produce positive outcomes.

- In Mississippi, an approach that promoted best practices, teamwork, and the development of clinical supervision skills led to improved perceptions among worker of their effectiveness and reduced turnover.c[404]
- In Missouri, a demonstration project in which workers observed supervisor models in actual and simulated treatment interventions led to both better case outcomes and to improved practice and morale among workers.[405]
- In Arkansas, supervisors who participated in field-based mentoring, structured case review, and online tutorials reported positive changes in their practice and in that of their caseworkers.[406]

After Arizona State University conducted a needs assessment of supervisors in the Arizona child welfare agency, the department and agency developed supervisor circles as part of ongoing, required supervisor training. Supervisors meet quarterly with their peers and their supervisors; they staff cases together, practice their decision-making skills, and obtain information on new agency policies and practices. As supervisors then pass on the skills and information to case workers, they help integrate better decision-making throughout the agency.

Policy Options: States can authorize and fund training and supports for supervisors using 1, 2, or 3 of the following approaches:

- Regular, ongoing supervisor training
- Field-based mentoring for supervisors
- Supervisor circles

16.5 Workplace technological tools and administrative supports.

In addition to quality supervision, other supports can help improve worker communication and relieve the administrative burdens of case documentation. In turn, these supports may help boost morale, retention, and performance. In addition, tools that reduce the time workers spend on paperwork, documentation and other administrative tasks can increase the time available to work directly with children and families.

According to the GAO, some workers report that they spend between 50 and 80 percent of their time completing paperwork. Illinois caseworkers report that they must complete more than 150 forms for each child in their caseloads.[407]

Agencies have developed a variety of strategies for relieving the burden of documentation for caseworkers. Alabama and Oregon are among those jurisdictions where public agency caseworkers deliver their notes from field visits to support staff, which then enter the information into the state data system.[408] Other agencies use call-in clerical services for this function, rather than child welfare agency staff. Iowa caseworkers use electronic tablets in the field to document their activities in a single step.

One of the goals of Iowa's legislatively authorized child welfare redesign was to reduce unnecessary paperwork for frontline staff. The Department of Human Services identified critical decision-making points for caseworkers, how decisions and actions are documented, and how the information is used. Planners then developed the Statewide Automated Child Welfare Information System (SACWIS) as a case management tool by aligning data reporting with critical case decision points. The system provides guidance for decision making by connecting workers with relevant policies and procedures as they provide services and document their actions. It also helps to ensure that critical information such as risk assessment findings, court hearing schedules, and reports are integrated into the child's case plan and passed along to appropriate staff. The system has helped to reduce paperwork, eliminate duplicative practices, and increase communication.

Access to cell phones, pagers, laptops, and other equipment allows workers to complete work during the downtime that occurs between appointments and court procedures and to stay in touch with office information and supervision. As part of Florida's efforts to improve child protective services, investigative staff are supplied with cell phones, digital cameras, and laptops.

Policy Options: States can enhance technological tools and administrative supports needed for documentation and communication by authorizing and funding either or both the following resources:

- Workers in the field equipped with wireless technology, such as laptops, PDAs, and other technological tools.
- Clerical staff or other resources allocated to enter data and document casework.

16.6 Minimum education standards.

Several studies report that caseworkers with Bachelor's of Social Work (BSW) and Master's of Social Work (MSW) degrees have higher job performance and lower turnover rates. In one study, child welfare staff with BSW and MSW degrees were found to be more effective in developing permanency plans.[409] Other research suggests that caseworkers with social work education and greater experience are better able to facilitate permanency than their peers.[410]

The National Association of Social Workers standards for caseworkers recommend that child welfare administrators and supervisors have an MSW and previous child welfare experience, and that direct service workers have, at least, a BSW from an accredited school of social work. However, a 1998 national child welfare workforce survey found that fewer than 15 percent of child welfare agencies required caseworkers to hold either bachelors or masters degrees in social work. The 2004 American Public Human Services Association (APHSA) survey of state child welfare administrators indicated that most states require a Bachelor's degree — although not necessarily a BSW — for all workers and supervisors who carry cases. Only two states reported requiring a Master's degree for supervisors.[411]

Policy Options: States can promote higher job performance and staff retention by requiring one or both of the following minimum education standards.

- BSW or BA in a human services field is required for entry level caseworkers
- MSW/MA is required for frontline supervisors

16.7 Opportunities and incentives for education, training and professional development.

Child welfare administrators rate improved pre-service training, orientation, in-service training, and educational opportunities among the most effective strategies for retaining workers. Although few programs have been rigorously evaluated, both workers and administrators report that high quality training and other professional development are important for recruitment, retention, and effective practice.

At the same time, workers from public and private agencies identify many shortfalls in the training and professional development opportunities offered. New worker training often fails to prepare caseworkers to do their jobs. Effective training, continuing education, and professional development opportunities are frequently lacking or inaccessible. For example, Kentucky caseworkers report that they do not participate in optional professional development opportunities because casework accumulates while they are in training. California staff said that a program designed to allow part-time work while they pursue an MSW is not practical because caseloads are not reduced and performance expectations do not change despite fewer work hours.[412]

States have developed a variety of strategies for providing opportunities and incentives for education, training and professional development. Dozens of states have used state funding combined with federal Title IV-E training dollars to form partnerships with universities and schools of social work to provide education and incentives for social work students to join the child welfare field and to train current caseworkers. Students receive tuition stipends in exchange for a commitment to

work in a public child welfare agency for a minimum, specified time — usually one to two years post education/graduation. In Kentucky and California, 86 and 85 percent of participants respectively continue their work beyond their minimum commitment.

Loan forgiveness, another highly rated strategy, allows a person who has master's education or is working toward a degree in social work or a related field to get part of their college education loan forgiven, if they commit to working for a public or private child welfare agency during or upon completion. For example, the Illinois Child Welfare Student Loan Forgiveness Program, created by the State Legislature in 2005, provides loan forgiveness for eligible students for upper-division undergraduate and graduate study in an approved social work or human services degree program. The maximum loan time period is two years and the maximum loan amount is $4,000 for undergraduate study and $8,000 for graduate study.[413]

Kentucky has developed a range of strategies aimed at providing opportunities and incentives for professional development and training:

- A control group study demonstrated better job preparation of participants in the Kentucky pilot Public Child Welfare Certification Program (PCWCP). This program is a baccalaureate social work education and skills development program that Kentucky's public child welfare agency and a consortium of the state's schools of social work jointly created and sponsored. The program features common curricula, practicum in child welfare agencies, completion of agency training for new workers before graduation, agency/faculty/student retreats, tuition and stipends, and two-year work commitments to the public agency after graduation.[414] Three years of studies reveal an 87 percent retention rate for graduates compared to 33 percent for non-participants, better permanency decisions and overall practice, and fewer reports of feeling overwhelmed by the job.[415]
- Another Kentucky program that pays tuition and a small stipend for MSW students also demonstrated a two-year retention rate of close to 87 percent.
- A unique Kentucky agency-university collaboration called Credit for Learning allows workers to earn graduate school credit for completion of specially designed courses offered by the agency Training Academy.[413] In addition, distance learning strategies, lodging for required training, and other strategies are used to make some training and professional development courses accessible for staff in rural areas of the state.

Policy Options: States can authorize and fund 1, 2, 3, or 4 of the following supports and incentives for education, training and professional development:

- Loan forgiveness
- Tuition reimbursement
- Stipends
- Other incentives and opportunities for graduate professional education

16.8 Education, training and professional development strategies that address critical practice issues.

Social work education, training and other professional development are intended to ensure that child welfare staff develops the general skills required to help children and families thrive. However, many staff reports that they do not feel adequately prepared for the specific work they do.

The National Association of Social Workers (NASW) standards state that workers require "knowledge related to child development, parenting issues, family dynamics, community/local systems where the client resides, and cultural competency standards and practices."[417] Other content areas that experts recommend include child and family screening and assessment, family protective factors, and the impact of trauma on social and emotional development.

To help children and families obtain the assistance they need, workers also need knowledge of how child welfare and other systems work and tools for navigating benefits and services. Staff surveys, focus groups, performance reviews and exit interviews can provide opportunities for workers and their supervisors to identify specific issues and areas that need to be addressed in training and professional development. For example, there is evidence that child welfare agencies, case workers and caregivers lack knowledge of Medicaid coverage, rules, or how to access services for children. Two national surveys of state agencies revealed that the eligibility policy for children in foster care reported by the state Medicaid agency is not consistent with Medicaid policy as reported by child welfare agencies.[418] The inconsistency in understanding caseworkers and caregivers who lacked basic information about the Medicaid program, received very little training regarding Medicaid services for foster children, and did not have the necessary tools to navigate the Medicaid system.[419]

Collaborative development and delivery of education and training with other experts can help child welfare workers develop the full contingency of skills needed to address specific problems that children and families experience. Because child

welfare and domestic violence programs share the goal of violence-free families, collaboration between the two may be especially strategic for preventing harm while keeping children with their non-abusing parent, safety planning for the child and family, and protection of child welfare workers. All state child welfare workers in Massachusetts are trained in how to recognize domestic violence in their cases and how to work with these families. In Michigan, through Families First, a domestic violence training curriculum developed specifically for family preservation workers allows them to respond more effectively to families referred by child protective services.[420]

Policy Options: States can authorize and fund training in accordance with either or both of the following requirements:

- Annual training and professional development for child welfare staff is required and in-service training curricula include content areas identified by national standards, experts, workers and supervisors as critical to achieving positive outcomes for children and families.
- Child welfare staff receives training in assessment, prevention and response to domestic violence within families involved with the child welfare system.

16.9 Adequate compensation and opportunities for advancement.

Child welfare salaries are deterrents to both recruitment and retention of skilled staff. Even though surveys of state child welfare agency administrators indicate that staff salaries have increased in the past several years, they have not kept pace with the cost of living. Perhaps more importantly for recruitment and retention, child welfare compensation remains significantly lower than salaries of public and private professionals with related qualifications or with comparable stress levels and decision-making responsibilities, such as nurses, public school teachers, policy officers and firefighters. The average annual salary of a child protective service worker in 2003 was $35,553 — $10,570 less than that of a teacher and $17,257 less than that of a registered nurse.[421]

Because low salaries contribute to limited applicant pools, they can present special challenges for recruitment of staff in certain geographical areas and for serving bilingual clients. According to Texas officials, counties in rural areas with large Spanish-speaking and Native American populations do not pay adequate salaries to successfully recruit qualified staff that are bilingual or sensitive to local cultures.[422]

States also report sizeable compensation disparities within the child welfare profession. A South Carolina study, for example, found that salaries for public agency caseworkers were almost twice those of direct care workers in private agency residential programs.[423]

A career ladder provides promotional opportunities through structured mobility in job series and contributes to staff recruitment and retention. Fewer than half the state child welfare administrators responding to the 2004 American Public Human Services Association (APHSA) survey reported that their state provides promotional opportunities through structured mobility in job services (a 'career ladder') for various child welfare staff positions and only 11 reported a career ladder for child welfare supervisors.[424]

Legislators in several states have funded salary increases as part of efforts to improve child welfare services. In Tennessee, for example, the state provided $3.2 million for salary enhancements in FY 2005, which were matched with $1.2 million in federal funds. In 2003, Florida legislators appropriated more than $30 million in state and federal funds for pay adjustments and authorized bonus payments.

Stipends and differential pay for bilingual workers help child welfare agencies respond to the cultural and linguistic diversity of families and children with whom they work by attracting staff with needed skills, encouraging workers to improve their skills, and rewarding employee efforts. Thirty-eight California counties offer a pay differential for bilingual social workers. The Arizona Department of Economic Security offers a stipend for frontline child welfare staff and supervisors who are proficient in Spanish, Navajo, Hopi, or sign language. In fiscal year 2004, 252 employees in Arizona took a verbal fluency exam administered by an independent contractor, and 191 were certified as bilingual. In El Paso County, Colorado, the Department of Human Services uses salary differentials for bilingual staff specifically to promote workforce diversity.[425]

Policy Options: States can authorize and fund compensation in accordance with 1, 2, or 3 of the following policies:

- Salaries of state child welfare staff are equal to those of other professionals with related qualifications.
- Career ladders provide promotional opportunities for child welfare agency staff.
- Stipends or differential pay reward bilingual staff for their skills.

16.10 Worker safety and protection.

There is evidence that child welfare field staff sometimes face serious threats to their safety. The National Association of Social Workers found that 19 percent of child welfare practitioners have been victims of violence and 63 percent have been threatened at some point in their careers.[426] A study by the American Federation of State, County and Municipal Employees (AFSCME) reported that more than 70 percent of frontline caseworkers had been victims of violence or threats of violence while in the line of duty. In a peer exit interview process conducted in Texas, 90 percent of child protective services employees reported that they had experienced verbal threats, 30 percent had experienced physical attacks, and 13 percent had been threatened with weapons.[427]

Safety strategies recommended by experts range from training in interview and assessment techniques that help workers gauge and diffuse the risk of violence to law enforcement escorts when potential for violence is high. Increasingly, cell phones or pagers that ensure workers' whereabouts are known and allow calls for back-up are considered essential to the safety of staff in the field. Other measures include availability of staff or supervisor back-up and team approaches, especially at times when safety may be an issue.[428]

California, New Jersey and Washington have adopted safety guidelines for social workers and caseworkers.[429] In Washington, legislation required establishment of an agency workgroup to develop policies and protocols to address the safety of child protective services and child welfare staff.[430] Kentucky legislation provided $3.5 million to fund security improvements at state child welfare offices, "panic buttons" for staff, and global positioning system capabilities to locate staff in the field.[431]

Policy Options: States can authorize and fund 1, 2, 3, or 4 of the following safety measures:

- Workers receive training in techniques for assessing the potential for danger and diffusing violence.
- Workers in the field are equipped with cell phones, pagers, and/or global positioning systems.
- Law enforcement escorts, staff teaming, and/or supervisor back-up are used when safety risks are indicated.
- Security procedures and safeguards are in place at child welfare agency offices

Policy Area 16: Skilled and Stable Workforce Summary of Policy Options

Policy Area	Policy Options
16.1 Monitoring and use of data to strengthen the work-force	**Promote the strength of the workforce by adopting one of the following policies (listed in order of increasing effectiveness):** • Exit surveys, periodic staff surveys and other agency communication strategies are conducted to monitor challenges, views and recommendations of staff. • Data regarding the status, characteristics, and views of the workforce are systematically and routinely monitored. • Quantitative and qualitative data are used to develop plans for strengthening the workforce.
16.2 Caseload limits for frontline workers	**Adopt and fund the implementation of one of the following policies (listed in increasing order of effectiveness):** • Caseloads do not exceed other standards set by the state. • Caseloads do not exceed Child Welfare League of America standards.
16.3 Appropriate supervisor to staff ratios	**Mandate that supervisor to staff ratios do not exceed nationally acceptable standards.**
16.4 Supervisor competencies and support	**Authorize and fund training and supports for supervisors using 1, 2, or 3 of the following approaches:** • Regular, ongoing supervisor training • Field-based mentoring for supervisors
16.5 Workplace technological tools and administrative supports	**Enhance technological tools and administrative supports needed for documentation and communication by authorizing and funding either or both the following resources:** • Workers in the field equipped with wireless technology, such as laptops, PDAs, and other technological tools. • Clerical staff or other resources allocated to enter data and document casework.
16.6 Minimum education standards	**Promote higher job performance and staff retention by requiring one or both of the following minimum education standards.** • BSW or BA in a human services field is required for entry level caseworkers • MSW/MA is required for frontline supervisors
16.7 Opportunities and incentives for education, training, and professional development	**Authorize and fund 1, 2, 3, or 4 of the following supports and incentives for education, training and professional development:** • Loan forgiveness • Tuition reimbursement • Stipends • Other incentives and opportunities for graduate professional education

Continued on page 169

Policy Area 16: Skilled and Stable Workforce Summary of Policy Options

Policy Area	Policy Options
16.8 Education, training and professional development strategies that address critical practice issues	Authorize and fund training in accordance with either or both of the following requirements: • Annual training and professional development for child welfare staff is required and in-service training curricula include content areas identified by national standards, experts, workers and supervisors as critical to achieving positive outcomes for children and families. • Child welfare staff receives training in assessment, prevention and response to domestic violence within families involved with the child welfare system.
16.9 Adequate compensation and opportunities for advancement	Authorize and fund compensation in accordance with 1, 2, or 3 of the following policies: • Salaries of state child welfare staff are equal to those of other professionals with related qualifications. • Career ladders provide promotional opportunities for child welfare agency staff. • Stipends or differential pay reward bilingual staff for their skills.
16.10 Worker safety and protection	• Authorize and fund 1, 2, 3, or 4 of the following safety measures: • Workers receive training in techniques for assessing the potential for danger and diffusing violence. • Workers in the field are equipped with cell phones, pagers, and/or global positioning systems. • Law enforcement escorts, staff teaming, and/or supervisor back-up are used when safety risks are indicated. • Security procedures and safeguards are in place at child welfare agency offices.

ENDNOTES

1 This funding is provided primarily by Title IV-E of the *Social Security Act*.
2 H.R. 6893, the Fostering Connections to Success and Increasing Adoptions Act of 2008 provides states with the option to use Title IV-E funding for guardianship subsidies for relatives. It also makes provisions for all children with special needs who are adopted from foster care to receive federal IV-E adoption assistance, not just those who are eligible for Title IV-E foster care.
3 National Governor's Association. 2006. *Policy Position HHS-14. Child Welfare Services.* Washington, D.C.: National Governor's Association
4 National Governor's Association. 2006. *Policy Position HHS-14. Child Welfare Services.* Washington, D.C.: National Governor's Association
5 H.R. 6893. 2008. *Fostering Connections to Success and Increasing Adoptions Act.* Section 402.
6 Washington State Institute for Public Policy. 2004. Benefits and Costs of Prevention and Early Intervention Programs for Youth. Olympia, WA: WSIPP. National Conference of State Legislatures. 2006. *State Child Welfare Legislation 2005*. Denver, CO: NCSL.
7 NCSL. *State Child Welfare Legislation 2005*.
8 National Conference of State Legislatures. 2007. *State Child Welfare Legislation 2006*. Denver, CO: NCSL.
9 Daro, Deborah. 2006. *Home Visitation: Assess Progress, Managing Expectations.* Chicago: Ounce of Prevent Fund and Chapin Hall Center for Children. http://www.chapinhall.org/article_abstract.aspx?ar=1438
10 NGA Center for Best Practices. 2002. *The Benefits and Financing of Home Visiting Programs*. Washington: National Governors Association. http://www.nga.org/cda/files/BENEFITSFINANCINGHOME.pdf
11 Olds D, Hill P, et al. Update on home visiting for pregnant women and parents of young children. Current Problems in Pediatrics. April 2000. 30(4):107-41.
12 Washington State Institute for Public Policy.
13 Thomas, D., Leicht, C., Hughes, C., Madigan, A., & Dowell, K. 2003. *Emerging Practices in the Prevention of Child Abuse and Neglect*. Washington, D.C.: U.S. Department of Health and Human Services, Children's Bureau Office on Child Abuse and Neglect. http://www.childwelfare.gov/preventing/programs/whatworks/report/report.pdf
14 Daro, D.
15 Johnson, Kay A. 2001. *No Place Like Home: State Home Visiting Policies and Programs.* New York, NY: Commonwealth Fund. http://www.cmwf.org/publications/publications_show.htm?doc_id=221347
16 Barth, R., Haskins, R., Wulczyn, F., Cherna, M., Simms, K., Blount, B., Hon. N. Johnson, Hon. J. Josey-Herring, & Knitzer, J. *Child Protection and Parent Training Programs.* Proceedings of the Brookings Institution Economic Studies and Center on Children and Families event, Washington, D.C., July 26, 2007. http://www3.brookings.edu/comm/events/20070726.pdf
17 Ibid.
18 Ibid.
19 Barth, R. *Building on Strengths: Current Status and Opportunities for Improvement of Parent Training for Families in Child Welfare.* Summarizing: Hurlburt, M., Barth, R.P., Leslie, L., Landsverk, J. & McCrae, J.M. 2007. *Building on Strengths: Current Status and Opportunities for Improvement of Parent Training for Families in Child Welfare*. In Haskins, R., Wulczyn, F., & Webb, M. B., (Eds.). Child protection: Using research to improve policy and practice (pp. 81-106). Washington, DC: Brookings Institution Press. http://www3.brookings.edu/comm/events/20070726.pdf
20 Hulbert, M. et al citing Mark Chaffin and others, *Parent-Child Interaction Therapy With At-Risk Families.* Child Welfare Information Gateway. http://www.childwelfare.gov/pubs/f_interactbulletin/
21 Thomas, D., et al. 2003. *Emerging Practices in the Prevention of Child Abuse and Neglect*. Washington, D.C.: U.S. Department of Health and Human Services, Children's Bureau Office on Child Abuse and Neglect. http://www.childwelfare.gov/preventing/programs/whatworks/report/report.pdf
22 ARCH National Respite Network. 2006 revised (2007). *Crisis Respite: Evaluating Outcomes for Children and Families Receiving Crisis Nursery Services.* Chapel Hill, N.C.: ARCH. http://www.archrespite.org/CN_Final_Revised.pdf
23 Thomas, D., et al.
24 Ibid.
ARCH National Respite Network
25 Center for the Study of Social Policy. 2004. *Policy Matters: Encouraging Strong Family Relationships.* Washington, D.C.
For example, 2005 Ariz. Sess. Laws, HB 2220, Chap. 220.
26 Wiedemeier Bower, J., Laws, R. 2002. *Support for Families of Children with Special Needs: A Policy Analysis of Adoption Subsidy Programs in the United States.* Saint Paul, MN: North American Council on Adoptable Children. http://www.nacac.org/pdfs/ForeverFamilies.pdf
27 Miller, J. Forthcoming. NEED TITLE FOR PAPER. Draft. Baltimore: Annie E. Casey Foundation.
Neergaard, L. 2007. *Study Says Foster Care Benefits Brains*. Associated Press Online, December 21, 2007.
28 Dignan, M., Burhansstipanov, L., Hariton, J., Harjo, L., Rattler, T., Lee, R., & Mason, M. 2005. *A Comparison of Two Native American Navigator Formats: Face-to-Face and Telephone. Cancer Control. Cancer, Culture and Literacy Supplement*: 28-33. http://www.moffitt.org/moffittapps/ccj//v12s5/pdf/28.pdf
Fischer, S., Sauaia, A., & Kutner, J. 2007. *Patient Navigation: A Culturally Competent Strategy to Address Disparities in Palliative Care. Journal of Palliative Medicine*. 10(5): 1023-1028. http://www.liebertonline.com/doi/abs/10.1089/jpm.2007.0070
Steinberg, M., Huang, D., Khan, D., Forge, N., Fremont, A., & Streeter, O. *The Use of Lay Patient Navigators to Improve Quality of Care and Accrual to Clinical Trials for Radiation Oncology Patients Who Are Minorities or of Low Socioeconomic Status*. *International Journal of Radiation OncologyBiologyPhysics* vol. 66 (3): S70-S70.

29 Triwest Group. 2005. Casey Family Programs, Kinship Caregiver Navigator Pilot, Final Pilot Evaluation Report. Seattle: Triwest.
30 Children's Defense Fund and Center for Law and Social Policy (2008). *Fostering Connections to Success and Increasing Adoptions Act (H.R. 6893) Summary*. Accessed at _____
31 Holsopple, K. The Vermont Family Support 360 Project. http://humanservices.vermont.gov/departments/ahs-fs-folder/peer-navigators/vermont-family-360-support-project/
32 Sedlak, A.J., & Broadhurst, D. D. 1996. *Third national incidence study of child abuse and neglect final report.* Washington: U.S. Department of Health and Human Services, as cited by Hutson, R. 2003. *A Vision for Eliminating Poverty and Family Violence: Transforming Child Welfare and TANF in El Paso County, Colorado*. Washington: Center for Law and Social Policy
33 Geen, R., Fender, L., Leos-Urbel, J., & Markowitz, T. 2001. *Welfare reform's effect on child welfare caseloads*. Washington, DC: The Urban Institute; as cited by Hutson, R.
34 Judge David L. Bazelon. Center for Mental Health. *An Evaluation of State EPSDT Screening Tools, Protecting Consumer Rights in Public Systems' Managed Mental Health Care Policy.* Washington, D.C.: Bazelon Center for Mental Health. http://www.bazelon.org/issues/managedcare/moreresources/epsdtfactsheet.htm
35 Doyle, J. 2007. *Child Protection and Child Outcomes: Measuring the Effects of Foster Care*. Forthcoming, *American Economic Review*. http://www.mit.edu/~jjdoyle/doyle_fosterlt_march07_aer.pdf Lawrence, C., Carlson, E., & Egeland, B. 2006. *The Impact of Foster Care on Development. Development and Psychopathology*, Cambridge University Press, 18: 57-76.
36 Neergaard, Lauran. *Study Says Foster Care Benefits Brains*. Associated Press Online, December 21, 2007. http://ap.google.com/article/ALeqM5gsqQ1c2wQoevMuODoXfV6p1O1vbQD8TLD4G80
37 Chairmen of the Senate Budget and Taxation Committee and House Committee on Appropriations. 2007 Session. *Report on the State Operating Budget (HB 50) and the State Capital Budget (HB 51) and Related Recommendations*. Annapolis, MD: Department of Legislative Services, Office of Policy Analysis.
38 Flynn-Kahn, M., Ferber, T., Gaines, E. & Pittman, K. 2006. *Adding It Up: A Guide to Developing a Children, Youth, and Families Budget.* Washington: Forum for Youth Investment and The Finance Project.
39 Ibid.
40 Ibid.
41 Westat, Chapin Hall Center for Children, and James Bell Associates. 2002. *Evaluation of Family Preservation and Reunification Programs: Final Report.* Washington, DC: U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation. http://aspe.hhs.gov/hsp/evalfampres94/final/
42 National Family Preservation Network, "What is IFPS?," http://www.nfpn.org/preservation/what-is-ifps/
43 Washington State Institute for Public Policy. 2006. *Intensive Family Preservation Programs: Program Fidelity Influences Effectiveness*. Olympia, WA. www.wsipp.wa.gov/rptfiles/06-02-3901.pdf
44 Berry, M., McCauley, K., & Lansing, T. (in press). Permanency through group work: A pilot intensive reunification program. *Child and Adolescent Social Work.;* Simmel, C. & Price, A. (2002). The Shared Family Care demonstration project: Challenges of implementing and evaluating a community-based project. *Children and Youth Services Review, 24*(6-7), 455-470.; Barth, R. & Price, A. (1999). Shared Family Care: Providing services to parents and children placed together in out-of-home care. *Child Welfare, LXXVIII,* 88-107.; Price, A. & Schmidbauer, S. (2003). Parenting immersion through Shared Family Care. *The Source,* 21-24.
45 Washington State Institute for Public Policy. 2006. *Intensive Family Preservation Programs: Program Fidelity Influences Effectiveness*. Olympia, WA. www.wsipp.wa.gov/rptfiles/06-02-3901.pdf
46 Kirk, R & Griffith, D. 2007. *An Examination of Intensive Family Preservation Services*. National Family Preservation Network. http://www.nfpn.org/tools—training/articles/ifps-research-report.html
47 The Governor's Office for Children. 2005. State of Maryland Report on Out-of-Home Placements and Family Preservation: Fiscal Years 1995 to 2005.
48 Wash. Rev. Code Sec. 74.14C.020.
49 Shireman, J., Rodgers, A., Alworth, J., Wilson, B., Gordon, L., Poirier, C., Workman, C., Howard, W., Maguire, M., Edder, K., Cahn, K., Spofford, Y., & Davis, K. 2001. *Strengths/Needs Based Services Evaluation, Final Report*. Portland, OR.: Portland State University, Graduate School of Social Work. http://www.cwp.pdx.edu/SOC/report%202001-final.pdf
50 Ibid.
51 Barth, R. & Price, A. 2005. Shared Family Care: Child Protection and Family Preservation in Action. In Scott, J. and Ward, H., Eds. *Safeguarding and promoting the wellbeing of children, families and communities* (pp. 197-227). London: Jessica Kingsley Publishers. Price, A. & Wichterman, L. 2003. Shared Family Care: Fostering the Whole Family to Promote Safety and Stability. Journal of Family Social Work, Special Issue on Child & Family Well-Being, 35-54.
52 CWLA 2008 Report on Substance Abuse..http://www.cwla.org/advocacy/2008legagenda13.pdf.
53 Physician Leadership on National Drug Policy.(March 1998). Press release of a study sponsored by the Physician Leadership on National Drug Policy; Finigan, M. (1996). *Societal outcomes & costs savings of drug and alcohol treatment in the state of Oregon.* Salem, OR: Office of Alcohol and Drug Abuse Programs, Oregon Department of Human Resources and Governor's Council on Alcohol and Drug Abuse Programs; as cited by Child Welfare League of America. *National Fact Sheet 2000.* http://www.cwla.org/advocacy/nationalfactsheet00.htm
54 U.S. Department of Health and Human Services. Substance Abuse and Mental Health Administration. 1999. *Blending Perspectives and Building Common Ground.* Washington, DC: Author as cited by Child Welfare League of America. National Fact Sheet 2000.
55 Arthur Liman Policy Institute. 2003. *Safe & Sound, Models for Collaboration Between the Child Welfare and Addiction Treatment Systems*. New York, NY: Legal Action Center.
56 U.S. Department of Health and Human Services. Substance Abuse and Mental Health Administration. *Blending Perspectives and Building Common Ground.*

57 Cite
58 Ibid.
59 Schmidt, J. & Dunne, L. 2004. Child Welfare Cases with Substance Abuse Factors, A Review of Current Strategies. Washington, D.C.: Voices for America's Children.
60 Rosack, J. 2001. *Moms in Drug Abuse Treatment Have Healthier Children. Psychiatric News* 36 (19): 5. http://pn.psychiatryonline.org/cgi/content/full/36/19/5
61 The Maryland General Assembly. *House Bill 7.* Child Welfare - Integration of Child Welfare and Substance Abuse Treatment Services, 2000. http//mlis.state.md.us/ 2000rs/billfile/Hb0007.htm as cited by Schmidt, J. & Dunne, L. 2004. *Child Welfare Cases with Substance Abuse Factors, A Review of Current Strategies*. Issue Brief. Washington, D.C.: Voices for America's Children.
62 Knight, D. K., & Wallace, G. 2003. *Where are the Children? An Examination of Children's Living Arrangements When Mothers Enter Residential Drug Treatment*. Journal of Drug Issues, 33(2), 305-324.
63 Killeen, T. & Brady, K. 2000. *Parental Stress and Child Behavioral Outcomes Following Substance Abuse Residential Treatment Follow-up at 6 and 12 Months. Journal of Substance Abuse Treatment* 19 (1): 23-29. *http://www.sciencedirect.com/science?_ob=ArticleURL&_udi=B6T90-40J7BB5-4&_user=10&_coverDate=07%2F31%2F2000&_rdoc=1&_fmt=&_orig=search&_sort=d&view=c&_acct=C000050221&_version=1&_urlVersion=0&_userid=10&md5=274eb5bcc07d450d60c1bf58ee779a72* Rosack.
64 Rosack, J. 2001. Moms in Drug Abuse Treatment Have Healthier Children. *Psychiatric News* 36 (19): 5. http://pn.psychiatryonline.org/cgi/content/full/36/19/5
65 P.L. 110-351. 2008. *The Fostering Connections to Success and Increasing Adoptions Act of 2008.*
66 Mental Health America. Factsheet: When a Parent Has a Mental Illness: Child Custody Issues. Alexandria, VA: MHA. http://www.nmha.org/go/information/get-info/strengthening-families/when-a-parent-has-a-mental-illness-issues-and-challenges-t
67 McCarthy, J. 2003. Creating Effective Systems for Mental Health Care and Services. *Best Practice/Next Practice*. Summer, 17-21.
68 Mental Health America. Factsheet: When a Parent Has a Mental Illness: Issues and Challenges. Alexandria, VA: MHA. http://www.nmha.org/go/information/get-info/strengthening-families/when-a-parent-has-a-mental-illness-issues-and-challenges-t
69 MHA. Factsheet: When a Parent Has a Mental Illness: Child Custody Issues.
70 Nicholson, J., Biebel, K., Hinden, B., Henry, A. & L. Stier. 2001. *Critical Issues for Parents with Mental Illness and Their Families*. Worcester, MA: Center for Mental Health Services Research, Department of Psychiatry, University of Massachusetts Medical School.
71 Landsverk, J., Burns, B., Stambugh, L.F., & Rolls Reutz, J. 2006. Mental Health Care for Children and Adolescents in Foster Care: Review of Research Literature. Seattle, WA: Casey Family Programs. http://www.casey.org/NR/rdonlyres/4E936037-7355-466C-8C94-F52D492C76EF/1112/MentalHealthReview.pdf
72 National Child Welfare Resource Center for Family-Centered Practice. 2003. "Mental Health Issues in the Child Welfare System." *Best Practice/Next Practice*, Summer, 1-6.
73 U.S. Department of Health and Human Services. 1999. *Mental Health: A Report of the Surgeon General—Chapter 3: Children and Mental Health*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health. www.surgeongeneral.gov/library/mentalhealth/pdfs/c3.pdf
74 New Freedom Commission on Mental Health. 2003. *Achieving the Promise: Transforming Mental Health Care in America. Final Report* (DHHS Pub. No. SMA-03-3832). Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration; Howell, E. 2004. *Access to Children's Mental Health Services under Medicaid and SCHIP*. Washington, D.C.: Urban Institute; Kataoka, S., Zhang, L., & Wells, K. 2002. *Unmet Need for Mental Health Care Among U.S. children: Variation by Ethnicity and Insurance Status. American Journal of Psychiatry, 159*(9), pp. 1548-1555.. as cited in Masi, R., & Cooper, J. 2006. *Children's Mental Health, Facts for Policymakers*. New York: National Center for Children in Poverty. http://www.nccp.org/publications/pdf/text_687.pdf
75 Garland, A. & Besinger, B. 1997. "Racial/Ethnic Differences in Court Referred Pathways to Mental Health Services for Children in Foster Care." *Children and Youth Services Review*, 19, 651-666 as cited by National Child Welfare Resource Center for Family-Centered Practice. 2003. "The Color of Mental Health in Child Welfare." *Best Practice/Next Practice*, Summer, 26-28.
76 Mental Health America. "Factsheet: When a Parent Has a Mental Illness: Child Custody Issues." Alexandria, VA: MHA. http://www.nmha.org/go/information/get-info/strengthening-families/when-a-parent-has-a-mental-illness-issues-and-challenges-t
77 United States General Accounting Office. 2003. *Child Welfare and Juvenile Justice: Federal Agencies Could Play a Stronger Role in Helping States Reduce the Number of Children Placed Solely to Obtain Mental Health Services.* Washington, DC. www.gao.gov/new.items/d03397.pdf
78 Bender, E. 2005. *State Seeks Solutions to Foster Care Crisis. Psychiatric News* (20) 2: 8. http://pn.psychiatryonline.org/cgi/content/full/40/2/8
79 Smithgall, C., Gladden, R. M., Yang, D. H., & Goerge, R. 2005. *Behavioral Problems and Educational Disruptions Among Children in Out-of-Home Care in Chicago* (Chapin Hall Working Paper). Chicago, IL: Chapin Hall Center for Children at the University of Chicago; Hurlburt, M. S.; Leslie, L. K.; Landsverk, J.; Barth, R.; Burns, B.; Gibbons, R. D.; Slymen, D. J.; & Zhang, J. 2004. *Contextual predictors of mental health service use among children open to child welfare. Archives of General Psychiatry, 61*(12), 1217-1224; Pecora, P., Williams, J., Kessler, R., Downs, C., O'Brien, K., Hiripi, E., & Morello, S. 2003. *Assessing the effects of foster care: Early results from the Casey National Alumni Study*. Seattle, WA: Casey Family Programs as cited in Masi, R., and Cooper, J.

80 Diamond, G. & Josephson, A. 2005. Family-based treatment research: A 10-year update. *Journal of the American Academy of Child and Adolescent Psychiatry, 44(9)*, 872-887.
81 Yannacci, Jacqueline & Rivard, Jeanne C. 2006. *Matrix of Children's Evidence-based Interventions.* National Association of State Mental Health Program Directors Research Institute, Inc. Center for Mental Health Quality and Accountability: Alexandria, VA.
82 U.S. Department of Health and Human Services 1999. *Mental Health: A Report of the Surgeon General—Chapter 3: Children and Mental Health*. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health: Rockville, MD. www.surgeongeneral.gov/library/mentalhealth/pdfs/c3.pdf
83 Mental Health America." Invisible Children's Project: Outcomes." http://www.mentalhealthamerica.net/go/about-us/what-we-do/programs-and-events/programs-and-events/invisible-children-s-project/invisible-children-s-project-outcomes/invisible-children-s-project-outcomes National Child Welfare Resource Center for Family-Centered Practice. 2003. "Helping the Invisible Children, Supporting parents with mental illness and their children." *Best Practice/Next Practice*. Summer, 22-25.
84 Mental Health America. "Factsheet: When a Parent Has a Mental Illness: Interventions and Services for Families." http://www.nmha.org/go/information/get-info/strengthening-families/when-a-parent-has-a-mental-illness-interventions-and-services-for-families
85 U.S. Department of Health and Human Services 1999. *Mental Health: A Report of the Surgeon General—Chapter 3: Children and Mental Health*. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health: Rockville, MD. www.surgeongeneral.gov/library/mentalhealth/pdfs/c3.pdf
86 Child and Adolescent Services Branch. *Wraparound Milwaukee. 2005 Annual Report*. Milwaukee, WI: Milwaukee County Behavioral Health Division.
87 Division of Children and Family Services. 2004. *Wraparound In Nevada for Children and Families, Program Accomplishments*. Carson City, NV: Department of Human Resources.
88 Harburger, D.S. & White, R.A. 2004. *Reunifying Families, Cutting Costs: Housing-Child Welfare Partnerships for Permanent Supportive Housing. Child Welfare* Washington, DC: Child Welfare League of America, Vol. LXXXIII, No. 5.
89 Culhane, J.F., Webb, D., Grim, S., Metraux, S., & Culhane, D. 2003. *Prevalence of Child Welfare Services Involvement Among Homeless and Low-Income Mothers: A Five-Year Birth Cohort Study. Journal of Sociology and Social Welfare,* 30, 79-95 as cited in Courtney, M.E., McMurtry, S.L., & Zinn, A. 2004. *Housing Problems Experienced by Recipients of Child Welfare Services. Child Welfare*, LXXXIII (5), 393-422. Washington, DC: Child Welfare League of America.
90 Dorre and Mihaly 1996, Hagerdorn 1995, & Thoma 1998, as cited in Harburger and White.
91 Harburger and White.
92 U.S. Department of Health and Human Services, Children's Bureau. 1997. *National Study of Protective, Preventive and Reunification Services Delivered to Children and Their Families*. Washington, DC: U.S. Government Printing Office as cited in Harburger and White.
93 Boyd, M.K., Derezotes, D., Duva, J., Gould, R., & Waheed, K. "Emerging Practices to Reduce Disproportionality in Child Welfare." Presentation, Child Welfare League of America, 2007 Adoption and Foster Care Training Conference, New Orleans, December 12, 2007.
94 Khadduri, J., Burnett, K. & D. Rodda, 2003. *Targeting Rental Production Subsidies.* Cambridge, Mass.: Abt Associates, Inc.
95 National Low Income Housing Coalition. 2003. as cited by Harburger and White.
96 Harburger and White.
97 Child Welfare League of America. "Family Unification Program FAQ." http://www.cwla.org/programs/housing/FUPfaq.htm
98 Rog, Debra J., Gilbert-Mongelli, Ariana M., & Ezell, Lunday. 1998. *The Family Unification Program, Final Evaluation Report*, Washington: Child Welfare League of America Press. Phillliber Research Associates. 2006. *Supportive Housing for Families*.
99 Federal Register, Volume 73, No. 227, November 24, 2008. Retrieved at http://www.nchcw.org/files/FUP/FUP%20NOFA%20NOV%2024%202008.pdf
100 Walton, E. 1998 in-home family focused reunification: A six year follow up of a successful experiment. *Social Work Research*, 21, 273-294; Fraser, M. W., Walton, E., Lewis, R.E., & Walton, W.K. 1996. An Experiment in Family Reunification: Correlates of Outcomes at One Year Follow-up. *Children and Youth Services Review*, 18, 335-361
101 National Alliance to End Homelessness, "Supportive Housing for Families Program, Connecticut," National Alliance to End Homelessness, http://www.endhomelessness.org/content/general/detail/1125
102 National Child Welfare Resource Center for Organizational Improvement. 2001. "New Domestic Violence Guidelines for Public Child Welfare Agencies." *Managing Care for Children and Families* (3), no.4: 1.
103 Mathews, M. 1999. "The Impact of Federal and State Laws on Children Exposed to Domestic Violence." The Future of Children 9 (3): 50-66
104 2001 Florida HB 1673, Chap. 50.
105 Ibid.
106 Alaska Stat. § 47.17.035 (1998), Ind. Code § 5-2-9-2.1 (1998), and S.D. Codified Laws § 26-7A-107 (1996) as cited by Mathews, M. .
107 Courtney, M.E., Skyles, A., Miranda, G., Zinn, A., Howard, E., & George, R.M. 2005. *Youth Who Run Away from Out-of-Home Care*. Chicago: Chapin Hall Center for Children, University of Chicago. http://www.chapinhall.org/article_abstract.aspx?ar=1382
108 Courtney, M.E., Dworsky, A., Cusick, G.R., Havlicek, J., Perez, A., & Keller, T. 2007. *Midwest Evaluation of the Adult Functioning of Former Foster Youth: Outcomes at Age 21, Executive Summary*. Chicago: Chapin Hall Center for Children, University of Chicago.
109 Conway, T. & Hutson, R. 2007. *Is Kinship Care Good for Kids?* Center for Law and Social Policy. http://www.clasp.org/publications/is_kinship_care_good.pdf
110 http://www.acf.hhs.gov/programs/cb/stats_research/afcars/tar/report14.htm.

111 Campbell, K.A., Castro, S., Houston, N., Koenig, D., Rose, J. & Smith, M.S. "Lighting the Fire of Urgency…Families Lost and Found in America's Child Welfare System".
112 P.L. 110-351. 2008. *Fostering Connections to Success and Increasing Adoptions Act of 2008*.
113 New York State Office of Children and Family Services. 2005. *Locating Absent Fathers and Extended Family, Guidance Paper*. Albany: State of New York.
114 American Bar Association Center for Children and the Law. n.d. *Statutory Preference for Relative Placement*. Washington: ABA. http://www.abanet.org/child/summary-memo.pdf
115 Ibid.
116 Robison, S., Miller, J., & Bissell, M. 2007. *Making "Relative Search" Happen, A Guide to Finding and Involving Relatives at Every Stage of the Child Welfare Process*. East Greenwich, R.I.: Child Focus Partners. www.childfocuspartners.com
117 Hess, P. 2003. Visiting Between Children in Care and Their Families: A Look at Current Policy. New York: National Resource Center for Family-Centered Practice and Permanency Planning, Hunter College.
118 Ibid.
119 St. Rose Youth and Family Center, Inc. *Family Reunification Program*. http://www.strosecenter.org/htmdocs/programs/family.html
120 Conway, T. & Hutson, R.Q. 2007. *Is Kinship Care Good for Kids? Washington, DC: Center for Law and Social Policy*; Hutson, R.Q. December 17, 2007. Presentation for National Governor's Association Webcast, *Supporting Kinship Families: What State Policymakers Can Do*. Washington, DC: NGA. http://www.nga.org/portal/site/nga/menuitem.9123e83a1f6786440ddcbeeb501010a0/?vgnextoid=bbe4edc8acf54110VgnVCM1000001a01010aRCRD
121 Courtney, M. & Needell, B. "Outcomes of kinship care: Lessons from California." In *Child welfare research review*. Vol. 2. J.D. Berrick, R.P. Barth and N. Gilbert, eds. New York: Columbia University Press, 1997, pp. 130 – 149
122 Main, R., Macomber, J.E., & Geen, R. 2006. *Trends in Service Receipt: Children in Kinship Care Gaining Ground,* Series B, No. B-68. Washington: The Urban Institute.
123 Hutson, Supporting Kinship Families.
124 Main, Macomber, and Geen.
125 Berrick, Jill Duer. 1988. "When Children Cannot Remain Home: Foster Family Care and Kinship Care," *The Future of Children* 8 (1): 72-87.
126 See, for example:
Barth, R. P.; Courtney, M.; Berrick, J. D.; & Albert, V. 1994. *From Child Abuse to Permanency Planning: Child Welfare Services Pathways and Placements.* New York: Aldine De Gruyter.
Berrick, J. D.; Barth, R. P.; & Needell, B. 1994. "A Comparison of Kinship Foster Homes and Foster Family Homes: Implications for Kinship Foster Care as Family Preservation," *Children and Youth Services Review,* 16: 33-63.
Chipungu, S. S.; Everett, J. E.; Verduik, M. J.; & Jones, H. 1998. *Children Placed in Foster Care with Relatives: A Multi-State Study.* Washington, D.C.: U.S. Department of Health and Human Services, Administration for Children and Families.
Main, R; Macomber, J; and Geen, R. May 2006. Trends in Service Receipt: Children in Kinship Care Gaining Ground, Urban Institute; Washington, DC. http://www.urban.org/UploadedPDF/311310_B-68.pdf
127 Cross, T., Simmons, D., Jackson, S., Robison, S., & Semidei, J. "How Does Subsidized Guardianship Respect Culture? Reflections of American, Native American and Latino Experiences," Bissell, M. & Miller, J.(eds). 2004 *Using Subsidized Guardianship to Improve Outcomes for Children.* Washington, DC.: Children's Defense Fund.
128 Testa, M. December 17, 2007. Presentation for National Governor's Association Webcast, *Supporting Kinship Families: What State Policymakers Can Do*. Washington, NGA. http://www.nga.org/portal/site/nga/menuitem.9123e83a1f6786440ddcbeeb501010a0/?vgnextoid=bbe4edc8acf54110VgnVCM1000001a01010aRCRD
129 P.L. 110-351. 2008. *Fostering Connections to Success and Increasing Adoptions Act of 2008.*
130 Maryland waiver demonstration findings can be found on the website for the Department of Health and Human Services at http://www.acf.hhs.gov/programs/cb/programs_fund/cwwaiver/2007/maryland.htm
131 Institute for Applied Research. 2008 "*Minnesota Permanency Demonstration: Interim Report,* July 2008, retrieved from: http://www.dhs.state.mn.us/main/groups/county_access/documents/pub/dhs16_143725.pdf
132 Ibid.
133 Ibid.
134 Bissell, M. and Miller, J., eds. 2004. *Using Subsidized Guardianship to Improve Outcomes for Children: Key Questions to Consider*. Washington, DC: Children's Defense Fund.
135 Wisconsin State Department of Health and Family Services. 2004. *Wisconsin Subsidized Guardianship Waiver, Excerpt from Federal Waiver Terms and Conditions*. http://www.legis.state.wi.us/lc/committees/study/2004/CHILD/files/oct20excerptmitch.pdf
136 Robison, S. 2006. *Preventive Subsidized Guardianship Programs: An Emerging Option for Permanent Kinship Care*. Houston, TX: Cornerstone Consulting Group. http://www.cornerstone.to/images/guardship_prev_state_progs.pdf
137 Ibid.
138 Children's Rights, National Foster Parent Association, and University of Maryland School of Social Work. 2007. *Hitting the M.A.R.C.: Establishing Minimum, Adequate Rates for Children*. http://www.childrensrights.org/pdfs/MARC/MARCSummaryReport.pdf
139 National Conference of State Legislatures. n.d. *Highlights of Recent Kinship Care State Legislative Enactments*. Denver: NCSL. http://www.ncsl.org/programs/cyf/kinshiphigh.htm
140 Hansen, M. 2006. *The Value of Adoption.* Washington: American University Department of Economics Working Paper Series, No. 2006-15.
141 Barth, R., Kwon Lee, C., Wildfire, J., and Guo, S. 2006. *A Comparison of the Governmental Costs of Long-Term Foster Care and Adoption*. Social Services Review. Chicago: University of Chicago.

142 Automated Foster Care and Adoption Reporting System. *Adoption of Children with Public Child Welfare Agency Involvement by State (1995-2006),* http://www.acf.hhs.gov/programs/cb/stats_research/afcars/adoptchild06.htm
143 Automated Foster Care and Adoption Reporting System, Department of Health and Human Services, Administration for children and Families, Children's Bureau. Preliminary FY 2006 estimates as of January 2008.
144 Hansen, M. and Hansen, B. 2005. *The Economics of Adoption of Children from Foster Care*. American University Department of Economics, Working Paper Series No. 2005-10. Retrieved at http://www.american.edu/academic.depts/cas/econ/workingpapers/2005-10.pdf
145 Institute for Applied Research. 2008. *Minnesota Permanency Demonstration: Interim* Report. Prepared for the Minnesota Department of Human Services. Retrieved at http://www.dhs.state.mn.us/main/groups/county_access/documents/pub/dhs16_143725.pdf
146 Virginia Health and Human Resources Budget, retrieved at http://leg1.state.va.us/081/bud/FinalSum/HHR30.PDF
147 2005 Conn. Acts, HB6940, P.A. 05-251
148 North American Council on Adoptable Children. *Federal Adoption Tax Credit for Special Needs Adoption Finalized in 2007*. Retrieved at http://www.nacac.org/postadopt/taxcredit.html
149 R.I. Pub. Laws, HB 5835, Chap. 401)
150 National Adoption Day. 2004. *Foster Care Adoption in the United States: A State by State Analysis of Barriers and Promising Approaches*. Conducted by the Urban Institute Child Welfare Research Program.
151 2005 N.Y. Laws, SB 5805, Chap. 3, Part A, Sec 35
152 (2005 Ga. Laws, HB 195, Chap. 75).
153 (2006 Tenn. Pub. Acts, SB 2644), Chap. 890)
154 Barth, R., Gibbs, D. and Siebenaler, K. 2002. *Assessing the Field of Post Adoption Services: Family Needs, Program Models, and Evaluation Issues,* Summary report submitted to the Department of Health and Human Services, Retrieved at http://aspe.hhs.gov/hsp/post-adoption01/summary/index.htm
155 Neergaard, L. 2007. Study Says Foster Care Benefits Brains. Associated Press Online, December 21, 2007.
156 Mech, E.V.,& Fung, C.C. 1999. *Placement Restrictiveness and Educational Achievement among Emancipated Foster Youth. Research on Social Work* 9, (2), *213-228.* Smithgall, C., Gladden, R. M., Howard, E., Goerge, R., & Courtney, M. E. 2004. *Educational Experiences of Children in Out-of-Home Care*. Chicago: Chapin Hall Center for Children. http://www.chapinhall.org/article_abstract.aspx?ar=1372
157 U.S. Department of Health and Human Services. 1999. *Mental Health: A Report of the Surgeon General—Chapter 3: Children and Mental Health*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health. www.surgeongeneral.gov/library/mentalhealth/pdfs/c3.pdf
158 Miller, J. Forthcoming.
159 Zinn, Andrew; DeCoursey, Jan; Goerge, Robert, & Courtney, Mark. 2006. *A Study of Placement Stability in Illinois*. Chicago, IL: Chapin Hall Center for Children. http://www.chapinhall.org/article_abstract.aspx?ar=1423
160 Ibid.
161 A Model for Public and Private Child Welfare Partnership Collaboration for change, Part One Family to Family Tools for Rebuilding Foster Care, Annie E. Casey Foundation, available at: http://www.aecf.org/MajorInitiatives/Family%20to%20Family/Resources.aspx#tools
162 Miller, J. Forthcoming.
163 Christian, S. April, 2002. National Conference of State Legislatures State Legistlative Report: *Analysis of State Actions on Important Issues, Supporting and Retaining Foster Parents*.
164 U.S. Department of Health and Human Services (1993). *National Survey of Current and Former Foster Parents.* Washington, DC.
165 Zinn, DeCoursey, Goerge, and Courtney.
166 Christian, S. April, 2002. National Conference of State Legislatures State Legistlative Report: *Analysis of State Actions on Important Issues, Supporting and Retaining Foster Parents*.
167 U.S. Department of Health and Human Services, Office of Inspector General. 2002. Retaining Foster Parents. Washington, DC: author, as cited in Children's Rights, National Foster Parent Association, and University of Maryland School of Social Work. 2007. Hitting the M.A.R.C.: Establishing Foster Care Minimum Adequate Rates for Children. New York: authors.
168 Children's Rights, National Foster Parent Association, and University of Maryland School of Social Work.
169 Neergaard, L.
170 Harden, B.J. 2002. *Congregate Care for Infants and Toddlers: Shedding New Light on an Old Question.* Infant Mental Health Journal, 23 (5), 476-495.
171 Miller, J. Forthcoming.
172 Ibid.
173 *Making Permanence a Reality for Children and Youth in Foster Care: Strengthening Policy at the Federal Level Casey Family Services; Children's Defense Fund 2006 available at: http://www.aecf.org/upload/PublicationFiles/CFS3622H5061.pdf*
174 Chamberlain, P. & Reid, J.B. 1998, *Comparison of two community alternatives to incarceration for chronic juvenile offenders.* Journal of Consulting and Clinical Psychology, 66 (4), 624-633.
175 Mockingbird Family Model Project Evaluation Year Three Evaluation Report Northwest Institute for Children and Families School of Social Work University of Washington http://www.mockingbirdsociety.org/mfmeval.php
176 The Mockingbird Family Model, The Mockingbird Society. http://www.mockingbirdsociety.org/model/index.php Northwest Institute for Children and Families, University of Washington, (2007), *Mockingbird Family Model, Project Evaluation, Year Three Evaluation Report* (2007). http://www.mockingbirdsociety.org/pdf/mfmreport5.pdf
177 Hegar, R.L. 2005. Sibling Issues in Child Welfare Practice. In Mallon, G.P. and Hess, P.M., Eds. Child Welfare for the Twenty-First Century: A Handbook of Practices, Policies, and Programs, pp. 536-557. New York: Columbia University Press.

178 Connell, James P., Gambone, Michelle Alberti, & Smith, Thomas J. *Youth Development in Community Settings: Challenges to Our Field and Our Approach,* Youth Development: Issues, Challenges and Directions, Community Action for Youth Project (A cooperative project of Gambone & Associates/ Institute for Research and Reform in Education)
179 American Academy of Pediatrics, Committee on Early Childhood, Adoption and Dependent Care. 2002. *Health Care of Young Children in Foster Care*. Pediatrics 103 (3): 536-541. Shonk, S. and Cicchetti, D. 2001. *Maltreatment, Competency Deficits, and Risk for Academic and Behavioral Maladjustment. Developmental Psychology,* 37(1), 3-17.
180 Putnam, F. W. 2006. *The Impact of Trauma on Child Development*. *Juvenile and Family Court Journal, 57*(1), pp. 1-11; U.S. Department of Health and Human Services. Administration on Children Youth, and Families. 2007. *Child Maltreatment 2005*. Washington, DC: U.S. Government Printing Office as cited by Cooper, J.L., Masi, R., Dababnah, S., Aratani, Y., Knitzer, J. 2007. *Strengthening Policies to Support Children, Youth, and Families Who Experience Trauma*. New York: National Center for Children in Poverty, Columbia University, Mailman School of Public Health.
181 Cloitre, M., Cohen, L. R., & Koenen, K. C. 2006. *Treating Survivors of Childhood Abuse: Psychotherapy for the Interrupted Life*. New York, NY: Guilford Press as cited by Cooper, J.L., Masi, R., Dababnah, S., Aratani, Y., Knitzer, J.
182 American Academy of Pediatrics.
183 Vandivere, Sharon; Chalk, Rosemary; & Moore; Kristin Anderson. 2003. *Children in Foster Homes: How are they Faring?* Child Trends: Washington, DC.
184 Horton, C. 2003. *Protective Factors Literature Review: Early Care and Education Programs and the Prevention of Child Abuse and Neglect.* Washington, DC: Center for the Study of Social Policy.
185 Center for the Study of Social Policy. 2004. *Protecting Children by Strengthening Families: A Guidebook for Early Childhood Programs.* Washington, DC.
186 Reynolds, Arthur J. and Robertson, Dylan L. 2003. *School-based Early Intervention and Later Child Maltreatment in the Chicago Longitudinal Study*, *Child Development, 74*(1), 3-26. As reported in Horton, Carol (2003). *Protective Factors Literature Review: Early Care and Education Programs and the Prevention of Child Abuse and Neglect.* Center for the Study of Social Policy: Washington, DC.
187 Zimmer, M.H., & Panko, L.M. 2006. Developmental status and service use among children in the child welfare system: A national survey. *Archives of Pediatrics & Adolescent Medicine, 160*(2), 183-188.
188 National Working Group on Foster Care and Education. 2007. *Fact Sheet: Educational Outcomes for Children and Youth in Foster and Out-of-Home Care*. Seattle, WA: Casey Family Programs. http://www.casey.org/NR/rdonlyres/A8991CAB-AFC1-4CF0-8121-7E4C31A2553F/1241/National_EdFactSheet_2008.pdf
189 National Conference of State Legislatures. 2004. *State Child Welfare Legislation: 2002-2003*. Denver, CO: NCSL.
190 Ibid.
191 Christian, S. 2003. *Educating Children in Foster Care*. Denver, CO: National Conference of State Legislatures.
192 Casey Family Programs. 2004. *A Roadmap for Learning: Improving Educational Outcomes in Foster Care*. Seattle, WA: author.
193 Christian, S. 2003.
194 Finkelstein, M., Warnsley, M., & Miranda, D. 2002. *What Keeps Children in Foster Care From Succeeding in School? Views of Early Adolescents and the Adults in Their Lives.* New York: Vera Institute of Justice.
195 Christian, S. 2003.
196 Ibid.
197 U.S. Department of Health and Human Services (HHS). 2005. *General Findings from the Federal Child and Family Services Review.* Washington: DHHS. http://www.acf.hhs.gov/programs/cb/cwrp/results/statefindings/genfindings04/genfindings04.pdf as cited by Geen, R., Sommers, A., and Cohen, M. 2005. *Medicaid Children on Foster Children*. Washington, DC: Urban Institute.
198 P.L. 110-351. 2008. *Fostering Connections to Success and Increasing Adoptions Act of 2008*.
199 Ibid.
200 Center for the Study of Social Policy. 2003. *Promoting Better Family Health: Recommendations for State Policy*. Washington: CSSP.
201 Geen, Sommers, and Cohen.
202 McCarthy, J. 2002. *Meeting the Health Care Needs of Children in the Foster Care System Summary of State and Community Efforts Key Findings*. Washington, DC: Georgetown University Child Development Center
203 Ibid. It is important to note that as of May, 2008, funding for TCM is threatened by recent federal regulatory changes that eliminate the use of TCM funds for children in foster care. Some states and members of Congress are challenging this policy change.
204 Pecora, Peter; Kessler, Ronald C.; Williams, Jason; O'Brien, Kirk; Downs, A. Chris; English, Diane; White, James; Hiripi, Eva; White, Catherine Roller; Wiggins, Tamara; and Holmes, Kate. 2005. *Improving Family Foster Care: Findings from the Northwest Foster Care Alumni Survey.* Seattle, WA.: Casey Family Programs.
205 Zinn, Andrew; DeCoursey, Jan; Goerge, Robert, and Courtney, Mark. 2006. *A Study of Placement Stability in Illinois.* Chicago, IL: Chapin Hall Center for Children. http://www.chapinhall.org/article_abstract.aspx?ar=1423
206 Yannacci, Jacqueline & Rivard, Jeanne C. 2006. *Matrix of Children's Evidence-based Interventions.* National Association of State Mental Health Program Directors Research Institute, Inc. Center for Mental Health Quality and Accountability: Alexandria, VA.
207 Ibid.
208 Cooper, J, Masi, R., Dababnah, S., Aratani, Y., & Knitzer, J. 2007. *Strengthening Policies to Support Children, Youth, and Families Who Experience Trauma*. New York: National Center for Children in Poverty. http://www.nccp.org/publications/pub_737.html
209 Ibid.
210 Pecora, P.J. et al. 2005. *Improving Family Foster Care: Findings From The Northwest Foster Care Alumni Study.* Seattle, WA: Casey Family Programs. http://www.casey.org/NR/rdonlyres/4E1E7C77-7624-4260-A253-892C5A6CB9E1/923/CaseyAlumniStudyupdated082006.pdf

211 American Academy of Pediatrics.
212 Casey Family Programs, *Roadmap for Learning*.
213 Office of Inspector General.
214 American Academy of Pediatrics.
215 Casey Family Programs, *Roadmap for Learning*.
216 P.L. 110-351. 2008. *Fostering Connections to Success and Increasing Adoptions Act.*
217 National Council of Juvenile and Family Court Judges. 2005. *Asking the Right Questions: A Judicial Checklist to Ensure that the Educational Needs of Children and Youth in Foster Care are Being Addressed*. Reno, NV: NCJFCJ.
218 Coutney, M. "Youth Aging Out of Foster Care." *Network on Transitions to Adulthood, Policy Brief*. April 2005 (19). http://www.transad.pop.upenn.edu/downloads/courtney—foster%20care.pdf
219 Courtney, Mark E. and Dworsky, Amy. 2005. *Midwest Evaluation of the Adult Functioning of Former Foster Youth: Outcomes at Age 19.* Chapin Hall Center for Children: Chicago, IL.
220 Pecora, Peter; Kessler, Ronald C.; Williams, Jason; O'Brien, Kirk; Downs, A. Chris; English, Diane; White, James; Hiripi, Eva; White, Catherine Roller; Wiggins, Tamara; and Holmes, Kate. 2005. *Improving Family Foster Care: Findings from the Northwest Foster Care Alumni Survey.* Casey Family Programs: Seattle, WA.
221 Pecora, et al.
222 Courtney and Dworsky.
223 Pecora, et al.
224 Ibid.
225 Courtney and Dworsky.
226 Courtney and Dworsky as cited by National Governor's Association, Center for Best Practices. 2007. *State Policies to Help Youth Transition Out of Foster Care*. Washington: NGA.
227 Courtney, Mark E. & Dworsky, Amy. 2005. *Midwest Evaluation of the Adult Functioning of Former Foster Youth: Outcomes at Age 19.* Chapin Hall Center for Children: Chicago, IL.
228 P.L. 110-351. 2008. *Fostering Connections to Success and Increasing Adoptions Act of 2008*.
229 National Governor's Association.
230 Wiedemeier Bower, Jeannette & Laws, Rita. 2002. *Support for Families of Children with Special Needs: A Policy Analysis of Adoption Subsidy Programs in the United States.* Saint Paul, MN: North American Council on Adoptable Children. http://www.nacac.org/pdfs/ForeverFamilies.pdf
231 Courtney, Mark E. & Dworsky, Amy. 2005. *Midwest Evaluation of the Adult Functioning of Former Foster Youth: Outcomes at Age 19.*
232 The Institution for Educational Leadership. 2008. *Foster Youth Demonstration Project, Final Evaluation Report*. Seattle, WA: Casey Family Programs. http://www.iel.org/pubs/caseyreport_finalreport.pdf
233 Ibid.
234 U.S. Advisory Board on Child Abuse and Neglect. 1980. *Child Abuse and Neglect: Critical First Steps in Response to A National Crisis.* Washington, DC: U.S. Government Printing Office
235 U.S. Advisory Board on Child Abuse and Neglect. 1993. *Neighbors Helping Neighbors: A New National Strategy for the Protection of Children.* Washington, DC: U.S. Government Printing Office
236 Korbin, J. and Coulton, C. 1997. Understanding the neighborhood context for children and families: Combining epidemiological and ethnographic approaches. In Brooks-Gunn, J., Ducan, G. and Aber, J.L. (Eds.) *Neighborhood Poverty. Volume II: Policy Implications in Studying Neighborhoods.* New York: Russell Sage Foundation. And Sampson, R., Raudenbush, S. & Earls, F. 1997. Neighborhoods and violent crime: A multilevel study of collective efficacy. *Science, 277*(August 15), 918-924.
237 Gragg, F., R. Cronin, D. Schultz, & Eisen, K. 2004. *National Evaluation Of The Safe Kids/Safe Streets Program: Final Report Volume I: Cross-Site Findings*, Washington, DC: OJJDP/Westat
238 Maryland Annotated Code, Human Services Article, Title 8-101 et. seq.
239 *The Development of Neighborhood-based Child Welfare Services in the District of Columbia*. 1998. Washington, DC: Center for the Study of Social Policy
240 *Working Together to Improve Results: Reviewing the Effectiveness of Community Decision-Making Entities*. August 2006 Revised. Washington, DC: Center for the Study of Social Policy
241 *Working Together to Improve Results: Reviewing the Effectiveness of Community Decision-Making Entities*. August 2006 Revised.
242 Department of Health and Human Services. 2000. *Evaluating Community Collaborations: A Research Synthesis*, by Michael Fishman, Mary Farrell, Vincena Allen and Elizabeth Eiseman, Washington, D.C. http://www.lewin.com/NR/rdonlyres/A4C9D9CE-8E51-4499-B935-6AE532C16E51/0/apr2000research564.pdf
243 O'Brien, M. 1997. *Financing Strategies to Support Comprehensive, Community-based Services for Children and Families*, Washington, DC: National Child Welfare Resource Center for Organizational Improvement
244 *Working Together to Improve Results: Reviewing the Effectiveness of CommunityDecision-Making Entities*. August 2006 Revised
245 Farrow, F. & Joe, T. 1992. Financing school-linked, integrated services. *Future of Children* 2:56-67
246 http://www.legis.state.ia.us/GA/79GA/Interim/2002/comminfo/progelim/handouts/DHSearlychild.pdf; http://www.johnson-county.com/auditor/min01/010628_1.htm; http://www.dhs.state.ia.us/docs/DECAT_FundingMatrix.pdf; http://www.senate.gov/~finance/hearings/testimony/2005test/051006jc.pdf
247 Virginia Acts of the Assembly, Chapter 80, Section 2.5-745
248 Hogan, C. 2001. *The Power of Outcomes: Strategic Thinking to Improve Results for Our Children, Families, and Communities* www.nga.org/cda/files/1999OUTCOMES.pdf
249 Bruner, C. 2006. Social Service Systems Reform in Poor Neighborhoods: What We Know and What We Need to Find Out, In *Community Change: Theories, Practice, and Evidence*. edited by Karen Fulbright-Anderson and Patricia Auspos. Washington, DC: Aspen Institute

250 *Vermont Communities Count: Using Results to Strengthen Services for Families and Children*. 2000. Baltimore, MD: Annie E. Casey Foundation
251 Farrow F. & Joe, T. 1992.
252 Parrott, S., D. Cohen Ross, & Schotti, L. 2000. *Streamlining and Coordinating Benefit Programs' Application Procedures*, Washington, DC: Center for Budget and Policy Priorities
253 *Building Partnerships with Neighborhoods and Local Communities Building Community Partnerships in Child Welfare*, Part One Family to Family Tools for Rebuilding Foster Care, Baltimore, MD: Annie E. Casey Foundation
254 Daro, D., Budde, S., Baker, S., Nesmith, A., & Harden, A. 2005. *Community Partnerships for Protecting Children: Phase II Outcome Evaluation FINAL REPORT*, Chicago, IL: Chapin Hall Center for Children at the University of Chicago:
255 Longhi, D. & Kohlenberg, E. 2003. Early Experiences in Service Integration: What We Can Learn from No Wrong Door Startups. Department of Social and Health Services, Research and Data Analysis Division: Olympia, Washington
256 Findlater, J. & Kelly, S. 1999. Child Protective Services and Domestic Violence, Domestic Violence and Children, *Future of Children*, Winter: 9(3)
257 *Customer Satisfaction- Improving Quality and Access to Services and Supports in Vulnerable Neighborhoods*. 2007. Washington, DC: Center for the Study of Social Policy
258 Bannister, W. 2007. Evaluation of the Piccard Integrated Service Delivery Pilot. Washington DC: Center for the Study of Social Policy.
259 *Fostering Health: Health Care For Children And Adolescents In Foster Care*. 2005. Task Force on Health Care for Children and American Academy of Pediatrics http://aappolicy.aappublications.org/cgi/reprint/pediatrics;109/3/536.pdf
260 Vandivere, S., Chalk, R. & Anderson Moore, K. 2003. *Children in Foster Homes: How are they Faring?* Washington, DC: Child Trends
261 Halfon, N., Inkelas, M., Flint, R., Shoaf, K., Zepeda, A. & Franke, T. 2002. *National Assessment of Factors Influencing the Adequacy of Health Care Services to Children in Foster Care,* National Center for Infant and Early Childhood Health Policy http://www.healthychild.ucla.edu/AssessmentFactors.asp
262 Wolverton, M. 2002. *Meeting the Health Care Needs of Children in the Foster Care System: Strategies for Implementation.* Washington, DC: Georgetown University Child Development Center
263 An Evaluation of State EPSDT Screening Tools, Bazelon Center for Mental Health, http://www.bazelon.org/issues/managedcare/moreresources/epsdtfactsheet.htm
264 Wolverton, M. 2002.
265 Wolverton, M. 2002.
266 United States Department of Education, Building the Legacy: IDEA 2004 http://idea.ed.gov/
267 Child Welfare Information Gateway http://www.childwelfare.gov/systemwide/service_array/development/childwelfare.cfm
268 "Massachusetts Early Childhood Linkage Initiative: Taking CAPTA Pilot to Scale" January 19, 2007 presentation by Kate Roper, MECCS, Massachusetts Department of Public Health, Division of Perinatal, Early Childhood & Special Health Needs, Boston, MA
269 Administration for Children and Families "Comprehensive Family Assessment Guidelines for Child Welfare" http://www.acf.hhs.gov/programs/cb/pubs/family_assessment/index.htm
270 An Evaluation of State EPSDT Screening Tools, Bazelon Center for Mental Health, http://www.bazelon.org/issues/managedcare/moreresources/epsdtfactsheet.htm
271 Hutson, R. 2003. A Vision for Eliminating Poverty and Family Violence Transforming Child Welfare and TANF in El Paso County, Colorado. CLASP: Washington, DC
272 McCarthy, J. 2002.
273 Texas Department of Family and Protective Services. 2006. *Family Group Decision-Making: October 2006 Final Evaluation*. www.dfps.state.tx.us/Documents/about/pdf/2006-10-09_FGDM_Evaluation.pdf
274 Myles E. & Tinworth, K. 2005. *Family Team Meeting (FTM) Process, Outcome, And Impact Evaluation*. Washington, DC: American Humane Association
275 Texas Department of Department of Family and Protective Services. 2006. *Family Group Decision-Making: October 2006 Final Evaluation*. www.Dfps.State.Tx.Us/Documents/About/Pdf/2006-10-09_FGDM_Evaluation.pdf
276 *The Association Of Team Composition And Meeting Characteristics With Foster Care Placement Recommendations* Thomas M. Crea *Boston College* Judith B. Wildfire Charles L. Usher *Jordan Institute For Families School Of Social Work The University Of North Carolina At Chapel Hill (In Draft, 2007)*
277 P.L. 110-351. 2008. *Fostering Connections to Succsess and Increasing Adoptions Act of 2008*
278 http://www.ncacdss.org/ncacdss/events/2003_SSI/documents/15DurhamISC.doc
279 Kan. Stat. Ann. §§38-1559
280 Coulton, C., Korbin, J., Su, M. & Chow, J. 1995. Community Level Factors and Child Maltreatment Rates, *Child Development* 66: 1262-1276. A. Sedlak and D. Broadhurst. 1996. *Third National Incidence Study of Child Abuse and Neglect*. Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families
281 Carter, V. & Myers, M. 2007. Exploring the risks of substantiated physical neglect related to poverty and parental characteristics: A national sample *Children and Youth Services Review* 29:110–121
282 *African American Children in Foster Care*. 2007. Washington, DC: Government Accounting Office www.gao.gov/cgi-bin/getrpt?GAO-07-816
283 Merkel-Holguin, L., Kaplan, C., & Kwak, A. 2006. *National Study On Differential Response In Child Welfare*, Washington, DC: American Humane Association and the Child Welfare League of America
284 Loman, L. & Siegel, G. 2004. *Differential Response in Missouri after Five Years Final Report*, St. Louis, Missouri: Institute of Applied Research
285 *Extended Follow-up Study of Minnesota's Family Assessment Response Final Report.* 2006. St. Louis, Missouri: Institute of Applied Research

286 Schene, P. & Oppenheim, S. 2005. *Choosing the Path Less Traveled: Strengthening California Families Through Differential Response* http://www.californiafamily resource.org/PDFs/Choosing%20the%20Path%20Less%20Traveled%20Strengthening%20CA%20Families%20through%20Differential%20Response.pdf
287 Merkel-Holguin, et. al.
288 http://www.casey.org/NR/rdonlyres/47C04B01-063F-4E13-8965-C7892267C523/1141/BSCDifferentialResponseCA.pdf
289 *Improving the Performance and Outcomes of Child Welfare through State Program Improvement Plans (PIPS): The Real Opportunity of the Child and Family Services Review*. 2003. Washington, DC: Center for the Study of Social Policy
290 Walley, P. 2007. The Next Step, *State News*, Washington, DC: Council of State Governments
291 2003 Iowa Acts, SF 453, Chap. 178
292 Bruner, C. 1998. *Defining the Prize: From Agreed-Upon Outcomes to Results-Based Accountability.* Des Moines, Iowa: National Center for Service Integration Clearinghouse
293 Child Welfare System Improvement and Accountability Act of 2001 (AB 636)
294 *Best Practices and Trends in Performance Based Contracting*. 2005. Washington State Office of Financial Management www.ofm.wa.gov/contracts/perf_based_contracting.pdf
295 *Literature Review on Performance-Based Contracting and Quality Assurance.* 2006. Planning and Learning Technologies, Inc. and The University of Kentucky www.uky.edu/SocialWork/qicpcw/documents/QICPCWPBCLiteratureReview.pdf
296 Shaver, M. 2006. *Performance Contracting in Illinois: Using Leverage to Drive Results* National Child Welfare Resource Center for Organizational Improvement
297 Human Systems and Outcomes, Inc
298 O'Brien, M. & Watson, P. 2002. *A Framework for Quality Assurance in Child Welfare*, National Child Welfare Resource Center for Organizational Improvement, University of Southern Maine: Portland, Me
299 Davidson, H.A., Cohen, C.P. & Girdner, I.K. eds. 1993. *Establishing Ombudsman Programs for Children and Youth: How Government's Response to Its Young Citizens Can Be Improved*. Washington, DC: American Bar Association Center on Children and the Law
300 National Conference of State Legislatures http://www.ncsl.org/programs/cyf/ombuds.htm
301 Bearup, R. & Palusci, V. 1999. Improving Child Welfare Through a Children's Ombudsman, *Child Abuse & Neglect* 23(5): 449-457
302 Fluke, Yaun J., Hedderson, J. & Curtis, P. 2003. Disproportionate Representation of Race and Ethnicity in Child Maltreatment: Investigation and Victimization, *Children and Youth Services Review*, 25: 359-373; U.S. Department of Health and Human Services. 2005. *Child Maltreatment,* Washington, DC: U.S. Government Printing Office
303 Hill, R.G. 2006. *Synthesis of Research on Disproportionality in Child Welfare: An Update*. Washington, DC: Casey/Center for the Study of Social Policy, Alliance for Racial Equity
304 Ards, S. 1992. Understanding patterns of child maltreatment. *Contemporary Policy Issues*. 10(4): 39-50. Korbin, J., C. Coulton, S. Chard, C. Platt-Houston, & M. Su. 1998. Impoverishment and children maltreatment in African American and European American neighborhoods. *Development and Psychopathology*, 10: 215-233. Hill, R.G. 2006. Synthesis *of Research on Disproportionality in Child Welfare: An Update* Washington, DC: Casey/Center for the Study of Social Policy, Alliance for Racial Equity, Sedlak, A., & Schultz, D. 2001. Race Differences in Risk of Maltreatment in the General Child Population. In Derezotes, D. M., Poertner, J. & Testa, M. F. (Eds.). *Race Matters in Child Welfare: The Overrepresentation of African American Children in the System.* Washington, DC: CWLA Press. AS CITED IN: Casey Family Programs 2006. *Disproportionality in the Child Welfare System: The Disproportionate Representation of Children of Color in Foster Care.* Seattle, WA.
305 Fluke, Yaun J., Hedderson, J. & Curtis, P. 2003. U.S. Department of Health and Human Services. 2005. *Child Maltreatment*
306 Hill, R.G. 2007. An Analysis of Racial/Ethnic Disproportionality and Disparity at the National, State, and County Levels. Washington, D.C: Casey/Center for the Study of Social Policy, Alliance for Racial Equity
307 *African American Children in Foster Care*. 2007. Washington, DC: Government Accounting Office www.gao.gov/cgi-bin/getrpt?GAO-07-816
308 Jones, E. 2006. *Places to Watch: Promising Practices to Address Racial Disproportionality in Child Welfare Services*. Casey-CSSP Alliance for Racial Equity. http://www.cssp.org/uploadFiles/Promising_Practices_to_Address_Racial_Disproportionality.pdf
309 *African American Children in Foster Care*. 2007.
310 *African American Children in Foster Care*. 2007.
311 http://www.casey.org/MediaCenter/Newsletter/Archive/2006Summer/DisproportionalityTX2.htm
312 2005 Mich. Pub. Acts, SB271, Act 147
313 *Equity- Moving Toward Better Outcomes for All of Michigan's Children.* 2006. Report from the Michigan Advisory Committee on the Overrepresentation of Children of Color in Child Welfare http://www.michigan.gov/documents/DHS-Child-Equity-Report_153952_7.pdf
314 Ibid.
315 Jones, E. 2006.
316 *African American Children in Foster Care*. 2007.
317 Jones, E. 2006.
318 Racial Equity Scorecard (Expanded Version) for Woodbury County, Iowa. 2007. Prepared by the Casey-CSSP Alliance on Racial Equity's Evaluation, Research and Data-based Decision Making Work Group in collaboration with Woodbury County Department of Human Services and the DMC Center at the University of Iowa.
319 *African American Children in Foster Care*. 2007.
320 *Equity- Moving Toward Better Outcomes for All of Michigan's Children.* 2006.
321 2004 Ill. Laws, SB 3208, PA 93-0867

322 Massachusetts House Committee on Child Abuse and Neglect. 2007. *First, Do No Harm*. http://www.mass.gov/legis/reports/HCCAN_report_3-28-07_Final.pdf
323 *Equity- Moving Toward Better Outcomes for All of Michigan's Children.* 2006.
324 *Juvenile Courts: Reforms Aim to Better Serve Maltreated Children*. 2000. Washington, DC: Government Accounting Office
325 P.L. 109–171
326 Fiermonte, C. & Sidote Salyers, N. 2005. *Improving Outcomes Together: Court and Child Welfare Collaboration,* www.fosteringresults.org
327 Pew Commission on Children in Foster Care. 2004. *Fostering the Future: Safety, Permanence and Well-Being for Children in Foster Care* http://pewfostercare.org/docs/index.php?DocID=41
328 Foster Court Improvement http://fosteringcourtimprovement.org/
329 *Justice For Children: Changing Lives By Changing Systems- A Call to Action.* 2005. Conference of Chief Justices, the Conference of State Court Administrators, the National Center for State Courts, and the National Council of Juvenile and Family Court Judges. Williamsburg, VA.: National Center for State Courts www.ncsconline.org/WC/Publications/CallToActionInside.pdf
330 Fostering Results, Improving Outcomes Together: Court and Child Welfare Collaboration. Chicago: Child and Family Research Center http://www.fosteringresults.org/results/reports/pewreports_06-22-05_improvingoutcomes.pdf.
331 Taitano, K. 2007. *Court-based Education Efforts for Children in Foster Care The Experience of the Pima County Juvenile Court*, Reno, NV: National Council of Juvenile and Family Court Judges
332 U.S. Department of Health and Human Services. 2007. *The National Evaluation of the Court Improvement Program Synthesis of 2005 Court Improvement Program Reforms and Activities- Final Report*, Washington, DC.
333 Green, B., Furrer, C., Worcel, S., Burrus, S. & Finigan, M. 2007. How Effective Are Family Treatment Drug Courts? Outcomes From a Four-Site National Study *Child Maltreatment* 12(1) : 43-59
334 Albrecht, L. *Drug Court is Beautiful.* www.4children.org/pdf/1103crt.pdf. Rush, A. *The San Diego Superior Court.* Mentor Court Profile, www.ndci.org/develop.pdf.
335 U.S. Department of Health and Human Services. 2007. *The National Evaluation of the Court Improvement Program Synthesis of 2005 Court Improvement Program Reforms and Activities- Final Report*, Washington, D.C.
336 Thoennes, N. 1997. An Evaluation of Child Protection Mediation in Five California Courts. *Family and Conciliation Court Review* 35(2)
337 U.S. Department of Health and Human Services. 2007. *The National Evaluation of the Court Improvement Program Synthesis of 2005 Court Improvement Program Reforms and Activities- Final Report*, Washington, D.C
338 U.S. Department of Health and Human Services. 2007. *The National Evaluation of the Court Improvement Program Synthesis of 2005 Court Improvement Program Reforms and Activities- Final Report*, Washington, DC
339 Frederick, W. & Sams, D. 2007. *A Child's Right to Counsel: First Star's National Report Card on Legal Representation for Children.* Washington, DC: First Star, Inc.
340 Frederick & Sams. 2007.
341 Lee, A., Genty, P. & Laver, M. 2005. *The Impact of the Adoption and Safe Families Act on Children of Incarcerated Parents,* Washington, DC: Child Welfare League of America
342 *National Court Improvement Progress Report and Catalog.* 2007. Washington, DC: National Child Welfare Resource Center on Legal and Judicial Issues, American Bar Association Center on Children and the Law http://www.abanet.org/abanet/child/home.cfm
343 Hudson, L., Klain, E., Smariga, M. & Youcha, V. 2007. *Healing the Youngest Children: Model Court-Community Partnerships*, Washington, DC: ABA Center on Children and the Law, Zero to Three Project
344 P.L. 110-351. 2008. *Fostering Connections to Success and Increasing Adoptions Act of 2008*.
345 Frederick & Sams
346 IN RE GAULT, 387 U.S. 1 (1967)
347 Miss. Code Ann. Section 43-21-201
348 Outley, A. *Representation For Children And Parents In Dependency Proceedings* Pew Commission Report http://pewfostercare.org/research/docs/Representation.pdf
349 U.S. Department of Health and Human Services. 2007. *The National Evaluation of the Court Improvement Program Synthesis of 2005 Court Improvement Program Reforms and Activities- Final Report*, Washington, DC
350 *National Court Improvement Progress Report and Catalog.* 2007. Washington, DC: National Child Welfare Resource Center on Legal and Judicial Issues, American Bar Association Center on Children and the Law http://www.abanet.org/abanet/child/home.cfm
351 *Best Practice Guidelines for Organizational Legal Representation of Children in Abuse, Neglect, and Dependency Cases*. 2006. Denver, CO: National Association of Counsel for Children
352 Outley, A. *Representation For Children And Parents In Dependency Proceedings* Pew Commission Report http://pewfostercare.org/research/docs/Representation.pdf
353 *Child Abuse and Neglect Cases: Representation as a Critical Component of Effective Practice.*1998. Reno, NV: National Council of Juvenile and Family Court Judges
354 http://www.abanet.org/child/clp/ParentStds.pdf
355 http://www.abanet.org/child/repstandwhole.pdf
356 http://www.abanet.org/child/agency-standards.pdf
357 National Association of Children's Counsel http://www.naccchildlaw.org/training/certification.html
358 Uniform Representation of Children in Abuse, Neglect, and Custody Proceedings Act http://www.nccusl.org/Update/ActSearchResults.aspx

359 *National Court Improvement Progress Report and Catalog.* 2007. Washington, DC: National Child Welfare Resource Center on Legal and Judicial Issues, American Bar Association Center on Children and the Law http://www.abanet.org/abanet/child/home.cfm
360 *State Children's Cabinets and Councils: Getting Results for Children and Youth*. 2007. Washington, DC: Forum for Youth Investment
361 Potter, D. & Mulkern, V. 2004. *Making The Case For Flexible Funding*. Issue Brief. Rutgers Center for State Health Policy, National Academy for State Health Policy http://www.cshp.rutgers.edu/TACCMSconfPapers/SEDBriefVMakingtheCaseFlexFund.pdf
362 Hayes, C. 2002. *Thinking Broadly: Financing Strategies for Comprehensive Child and Family Initiatives*, Washington, DC: Finance Project
363 Rust, B. 2000. DeCat in the Hat- Iowa's First Successful Step Towards Devolving Resources, Responsibilities and Accountability for Child and Family Outcome, *Advocacy,* Baltimore, MD: Annie E. Casey Foundation
364 O'Brien, M. 1997.
365 Horsch, K. 1996. *Issue Topic: Results-Based Accountability theory & practice. Results-Based Accountability Systems: Opportunities and challenges*. The Evaluation Exchange, II, 1. http://www.gse.harvard.edu/hfrp/eval/issue3/theory1.html.
366 Friedman, M. 2005. *Trying Hard is Not Good Enough*. Canada: Trafford
367 Maryland State Department of Education http://www.marylandpublicschools.org/NR/rdonlyres/BCFF0F0E-33E5-48DA-8F11-28CF333816C2/12398/School_Readiness_Report_2006_2007_CES.pdf
368 *Wisconsin Juvenile Justice Information Sharing Study*. 2005. Wisconsin Office of Justice Assistance http://oja.state.wi.us/docview.asp?docid=6690&locid=97
369 See sample Interagency Agreement on Information Sharing from the Child Welfare League http://www.cwla.org/programs/juvenilejustice/informationsharingsample.pdf
370 A *Road Map for Learning Improving Educational Outcomes in Foster Care: A Framework For Education Practice*. 2004. Seattle, WA: Casey Family Programs
371 Office of Juvenile Justice and Delinquency Prevention. 2006. *Guidelines for Juvenile Information Sharing - Develop JIS Policies, Procedures, and Practices* Washington. DC http://www.eric.ed.gov/ERICDocs/data/ericdocs2sql/content_storage_01/0000019b/80/27/fd/35.pdf
372 Bruns, E.J., Rast, J., Walker, J.S., Peterson, C.R., & Bosworth, J. 2006. Spreadsheets, service providers, and the statehouse: Using data and the wraparound process to reform systems for children and families. *American Journal of Community Psychology*, 38:201-212
373 Smith, D., Witte T. & Fricker-Elhai, A. 2006. Service Outcomes in Physical and Sexual Abuse Cases: A Comparison of Child Advocacy Center-Based and Standard Services, *Child Maltreatment* 11(4): 354-360; Snell, L. 2003. *Child Advocacy Centers: One Stop on the Road to Performance-based Child Protection,* Los Angeles, CA: Reason Public Policy Institute
374 Idaho Department of Health and Welfare hp://healthandwelfare.idaho.gov/site/3333/DesktopDefault.aspx?PageID=3333
375 Hayes, C. 2002.
376 Hutson, R. 2004. *Providing Comprehensive, Integrated Social Services to Vulnerable Children and Families: Are There Legal Barriers at the Federal Level to Moving Forward?* Washington, DC: Center for Law and Social Policy
377 Government Accountability Office. 2003. *Child Welfare: HHS Could Play a Greater Role in Helping Child Welfare Agencies Recruit and Retain Staff*. Washington, D.C.: GAO.
378 GAO. 2003.
379 American Public Human Services Association. 2005. *Report from the 2004 Child Welfare Workforce Survey: State Agency Findings.* Washington, D.C.: APHSA.
380 Robison, S. 2006. *Toward a High Quality Child Welfare Workforce: Six Doable Steps*. Houston, TX: Cornerstones for Kids. http://www.cornerstones4kids.org/images/six_doable_steps_406.pdf
381 Flower, C., McDonald, J. & Sumski, M. 2005. *Review of Turnover in Milwaukee County Private Agency Child Welfare Ongoing Case Management Staff*. Wheaton, IL: Jess McDonald and Associates. http://www.jessmcdonald.a25hourdaysites.com/f/Wisconsin_Report.pdf
382 National Council on Crime and Delinquency. 2006. *Relationship Between Staff Turnover, Child Welfare System Functioning and Recurrent Child Abuse*. Houston, TX: Cornerstones for Kids,
383 GAO. 2003.
384 Ibid.
385 2003 Texas Laws, HB 1, Chap. 1330
386 GAO. 2003.
387 U.S. General Accounting Office. 2006. Child welfare: Improving social service program training and technical assistance information would help address long-standing service-level and workforce challenges. (GAO-07-75). Washington, DC: GAO.
388 National Conference of State Legislatures. 2005. Funding of Child and Family Services Reviews Program Improvement Plans. Denver, CO: NCSL. http://www.ncsl.org/print/cyf/fundingcfsr.pdf
389 GAO. 2003.
390 National Association of Social Workers. Government Relations Update, Child Welfare Workforce.
391 Tittle, G. 2002. *Caseload Size in Best Practice, Literature Review*. Urbana, IL: Child and Family Research Center, School of Social Work, University of Illinois at Urbana-Champaign. http://cfrcwww.social.uiuc.edu/LRpdfs/CaseloadSize.LR.pdf
392 2003 Ariz. Sess. Laws, Second Special Session, HB 2024, Chap. 6; 2005 Ariz. Sess. Laws, SB 1513, Chap. 286
393 2005 Ind. Acts, HB 1001, P.L. 246 as cited by The National Conference of State Legislatures. 2006. *State Child Welfare Legislation 2005*. Denver, CO: NCSL.
394 2005 Md. Laws, HB 150, Chap. 443.

395 Circle Solutions, Inc. 1994. *Crisis Intervention in Child Abuse and Neglect: The Crisis Intervention Worker*. Washington, DC: U.S. Department of Health and Human Services. http://www.childwelfare.gov/pubs/usermanuals/crisis/crisish.cfm
396 Institute for the Advancement of Social Work Research. 2005. *Factors Influencing Retention of Child Welfare Staff: A Systematic Review of Research*. Washington, DC: IASWR. www.iaswresarch.org Robison, S. 2006.
397 The Child Welfare Training Institute. "Role of Supervisor." University of Southern Maine, Edward S. Muskie School of Public Service. http://www.cwti.org/RR/RoleSup.htm
398 GAO. 2003.
399 APHSA. 2005.
400 Izmir, G., Yackoub, E., & Moss, W. 2007. Technical Report 2: Caseloads in Child and Family Services. New South Wales, Australia: Department of Community Services. http://www.community.nsw.gov.au/docswr/_assets/main/documents/caseloads_report.pdf
401 Mary Nelson, Administrator, Division of Child and Family Services, Iowa Dept of Human Services: Testimony before the U.S. House Ways and Means Committee, May 15, 2007.
402 Collins-Camargo, C. *Enhancements to Supervisors and Mentoring to Improve Practices.* Presentation at Workforce Development and Workforce Enhancement Institute, The Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services, October 24-25, 2005. Washington, D.C. in The Child Welfare Training Institute. "Role of Supervisor."
403 GAO. 2003.
404 Children's Bureau. 2008. "Enhancing Casework Supervision: The Southern Regional QIC for Child Protection." *Children's Bureau Express* 8, (11). http://cbexpress.acf.hhs.gov/articles.cfm?issue_id=2007-12&article_id=1451
404 GAO. 2003.
405 Ibid.
406 Ibid.
407 GAO. 2003.
408 Robison. 2006.
409 Albers, E., Reilly, T., & Rittner, B. 1993. "Children in foster care: Possible factors affecting permanency planning." *Child and Adolescent Social Work Journal,* 10(4) as cited by National Association of Social Workers, "Child Welfare Workforce, Government Relations Update, http://www.socialworkers.org/advocacy/updates/2003/082003_a.asp.
410 Ahart, A., Bruer, R., Rutsch, C., & Zaro, S. 1992. *Final report: intensive foster care reunification programs*). Calverton, MD: Macro International; Albers et al.; Walton, E., Fraser, M. W., Pecora, P., & Walton, W. 1993. "In-home family-focused reunification: An experimental study." *Child Welfare*, 72(5), 473–487 as cited by Children's Bureau. 2006. *Family Reunification: What the Evidence Shows*. Washington, DC: U.S.Department of Health and Human Services Administration on Children, Youth and Families. http://www.childwelfare.gov/pubs/issue_briefs/family_reunification/family_reunification.pdf
411 Child Welfare League of America. 1999. "Minimum Education Required by State Child Welfare Agencies, Percent, By Degree Type, 1998." State Child Welfare Agency Survey. Washington, DC: Child Welfare League city be the GAO, 2003.
412 GAO. 2003.
413 2005 Ill. Laws, HB 1343, P.A. 94-0497
414 Fox, S. R., Miller, V. P., & Barbee, A. P. 2003. Finding and keeping child welfare workers: Effective use of Title IV-E training funds. *Journal of Human Behavior and the Social Environment, 7*(1/2), 67–81.
415 Steve Fox, Director of University Relations, University of Kentucky. Interview with author, April 7, 2005.
416 Ibid.
417 National Association of Social Workers. 2005. NASW Standards for Social Work Practice in Child Welfare. Washington, DC: NASW.
418 Inkelas, M. & Halfon, N.
419 Office of Inspector General. 2003. *Foster Children's Use of Medicaid Services in New Jersey*. Washington: U.S.Department of Health and Human Services.
420 Aron, L.W. & Olson, K. 1997. Efforts by Child Welfare Agencies to Address Domestic Violence, The Experiences of Five Communities. Washington: Urban Institute. http://www.urban.org/publications/406798.html
421 APHSA. 2005.
422 GAO. 2003.
423 GAO. 2003.
424 APHSA. 2005.
425 Robison. 2006.
426 Torres, K. 2007. "Social Worker Safety Bill Introduced." *Occupational Hazards*. http://www.occupationalhazards.com/News/Article/66244/Social_Worker_Safety_Bill_Introduced_.aspx
427 American Federation of State, County, Municipal Employees. 1998. *Double Jeopardy: Caseworkers at Risk Helping At-Risk Children: A Report on the Working Conditions Facing Child Welfare Workers.* Washington, DC: AFSCME as cited by GAO. 2003.
428 Circle Solutions. 1994.
429 Torres. 2007.
430 2005 Wash. Laws, HB 2189, Chap. 389
431 2007 Kentucky SB 59

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